Anorexia nervosa: symptoms and interventions

Anorexia Nervosa is the first eating disorder accentuated by severe weight loss or not enough weight gain in children as they grow. This disorder can be traced back as early as the 1200s. In those early days of anorexia mirabilis as the diagnosis called, based primarily on spiritual or religious purity rituals. People believed in self-starvation to be a sacrifice needed to reach the purity of one's soul. As it progressed into the Renaissance period, the disorder slowly evolved less of religious fasting but more of a spiritual and material belief fasting, however, the medical reasons increased especially in the 18 th century. In 1770, Phthisiologia or a Treatise of Consumptions" was penned by Morton. This outlined, " Nervous atrophy", a state of self-imposed limited food intake. Morton stated that this condition was caused by an " ill and morbid state of the spirits", supposing a psychological etiology.

Poets like Lord Byron, often described beauty in women as a pale, languid body while being mysterious and melancholy in nature. The last fifty years or so, the socially acceptable body as beautiful, changed with the growing industrialization period. Each decade our idea of what is beautiful became thinner as the fitness craze became abundant.

As this mental and physical trait grew globally, so did the approach to diagnose and approach the disorder. Darwin first categorized self-starvation, which leads to death as women focusing on the idea of being too fat. A paper is written in 1860 that which is noted as the first to describe the nosography of what we currently define as AN in a proper psychiatric point of view. He used two clinical cases depicting the delusional thoughts leading to food refusal. Clinical points of view of food-refusal increased in the second half of the 19 th century.

Gull, first to use “ anorexia nervosa” to reclassify the disorder from “ hysteria”, and became considered a psychological disorder. He and Lasegue wrote the first complete medical description of anorexia. It was the first eating disorder placed into the Diagnostic and Statistical Manual of Mental Disorder (DSM-1) first edition.

Many theories constructed in its early days of clinical acceptance as a disorder; hormonal etiology, psychological etiology along comes the “ anorexigenic family” association with the development of AN. Working with patients both Bruch and Palazzoli confirmed theories that disturbed perceptions of the body as a prime feature of AN as well as lacking an autonomous sense of self. Thus making it hard to understand the conceptualization of individuation and separation from the family. Palazzoli also confirmed that the anorexic takes extreme control over their own body because all other aspects of her life feel out of control. Many others have had input into trying to understand this disorder and how to diagnose it and approaches to treat the disorder.

As psychologists try to diagnose this disorder, many find that the disorder is really the tip of the iceberg. Like an onion it this illness has many layers. Depression, anxiety, obsessive-compulsive disorders, and others sit below the surface of the disorder. Researchers started to focus on behavioral traits with keeping in line with the spectrum approach helps overcome the limitations of the diagnosis for eating disorders. Having a ‘ spectrum approach” with this disorder may make diagnosing this illness much easier. As human beings are all different so are the psyche of these same individuals. The criteria of diagnosing Anorexia Nervosa is extreme just as

the disorder inflicts. Below is the ICD-10 criteria for diagnosing Anorexia Nervosa. All five criteria must be present for a definite and accurate diagnosis.

Body weight maintained at least 15% below that expected (either lost or never achieved) or body-mass index is 17. 5 or less. Prepubertal patients may fail to gain the expected amount of weight during the prepubertal growth spurt.

Weight loss is self-induced by avoiding " fattening foods" together with self-induced vomiting, purging, excessive exercising, or using appetite suppressants or diuretics (or both)

Body image distorted in the form of specific psychopathology whereby a dread of fatness persists as an intrusive, overvalued idea and the patient imposes a low weight threshold on himself or herself.

A widespread endocrine disorder involving the hypothalamic-pituitary-gonadal axis is manifest in women as amenorrhea and in men as a loss of sexual interest and potency (except for the persistence of vaginal bleeds in women who are taking replacement hormonal therapy, usually the contraceptive pill). Concentrations of growth hormone and cortisol increased, and changes in the peripheral metabolism of thyroid hormone and abnormalities of insulin secretion seen.

If onset is before puberty, the sequence of pubertal events delayed or even arrested (growth will cease; in girls, the breasts will not develop and primary amenorrhea will be present; in boys, the genitals will remain juvenile). After

recovery, puberty will often complete normally, but the menarche will be late.

Patients usually do not set out to become a person with anorexic tendencies. It starts emotionally for most. Self-loathing is a common statement from patients. It starts with wanting to lose weight. Trying to become thinner and prettier. This stems from social media and reactions from peers and potential " mates". Once the few pounds are gone, the fear of gaining it back intensifies, along with the good feeling of the weight-loss steps in. This feeling is addictive. The exercise becomes competitive in itself. You think everyone is against you if they keep you from exercising or wants you to eat the extra calories. You feel alone and the cycle keeps going. Your eyes no longer see you in the mirror. The self-distortion takes place and all you see if a " fat person" staring back at you. The reality is the person staring back at you is dying a slow and painful death.

Family and friends typically intervene and force the person to the hospital. The doctors then make the diagnosis and thus begins the battle, and a battle it will be.

Once the diagnosis is established, treatment plans need to implemented. Treatments tend to individualized based on the patients response levels with methods used in the past. Unfortunately, there are no psychiatric drugs effective in treating anorexia. Therapies used in eating disorders range or include motivational enhancement therapy, dynamically informed therapy, group therapy, family work, conjoint therapy, separated family therapy, multifamily groups, relatives' support groups. Recovery for this disorder for

true success is in the years, minimum five years and can last twelve years or longer. Some individuals is the rest of their lives. This illness is dangerous. It kills. Psychologists and medical doctors take eating disorders very seriously.

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