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WOMEN'S
HEALTH

Anorexia Nervosa

Anorexia nervosa affects 5% of the young female population in the UK. Children from ethnic minority background especially the boys are less likely to be anorexia nervosa sufferers. Twenty percent of the population who are affected by it dies twenty years after they become sufferers of anorexia nervosa.

In Australia two to four percent of its entire population is affected by anorexia nervosa and this population is predominantly female.

Health care provision in both countries involves psychosocial support as well as careful feading strategies.

The national collaborating center for mental health (NCCM) describes anorexia nervosa as a condition where an individual's obsession with body weight and their fear of appearing obese leads to them maintaining a weight much lower than their healthy ideal weight; a body mass index below 17.5 kg/m2. This weight is attained by abstaining from eating fatty food, excessive physical activity and purging that is self induced by laxative use or by vomiting. A low BMI has implications on the body's endocrine system; the hypothalamic-pituitary-gonadal axis becomes impaired leading to loss of libido and potency in men and amenorrhoea in women. As the individual is severely malnourished if they haven't reached puberty anorexia nervosa can cause a delay in growth and stunting.

An individual with anorexia nervosa has a strongly held belief that weight control is absolutely essential and that whoever considers their weight as abnormal and below the normal is not right. A person with anorexia nervosa has a wrong perception of their body image, they are convinced they are fat when in fact they have a normal body habitus. The affect of this strongly held belief then results in them working towards losing weight and any achievements they make in weight reduction and any compliments they may get for losing weight makes them feel as if they have achieved something positive, increasing their self esteem. As the tight weight control has such a huge affect on their confidence, it becomes difficult to then convince them of the seriousness of their situation. The NCCM believe that the fear of weight gain and obesity may be culture specific. The entire process begins with dieting that initially is not perceived by the people around this individual as problematic, any weight loss that receives positive compliments reinforces the weight loss behavior eventually leading to the development of anorexia nervosa.

The person becomes so committed to and obsessed with dieting that they become socially withdrawn focused on their goal of losing weight. This strong obsession with losing weight could also have an impact on a person's education and their job.

For some anorexia nervosa sufferers the route to developing anorexia nervosa does not begin with dieting it starts by purging. People who are sufferers of chronic diseases such as crohn's disease or diabetes may are also become sufferers of anorexia nervosa. As people with anorexia nervosa do not consider their dieting or weight losing behavior as abnormal, general practitioners, family members and teachers or other people are usually the first people to become concerned about their behavior and will often persuade an individual to seek help. Sometimes an individual may have some perception of their obsession with weight loss and their weight losing behavior and seek for help themselves.

An adolescent or a child with anorexia nervosa is often taken to the GP for help by parents.
(Bryant-Waugh et al (1992)

Diagnosis

The diagnosis of anorexia nervosa involves an assessment interview. A lot of empathy and support is involved in the conductance of this interview so that the patient's diet habits, their fears surrounding their body image and weight can be fully explored and any treatment offered can be tailored to this individual's psychological needs. If support, empathy and understanding are missing in the conductance of this interview then important information about diet habits such as purging or excessive exercise and fears around weight gain may be missed and the health practitioner may then have to resort to countless investigations to reveal the real cause of a low BMI.

In young adults and children the diagnosis is made by taking a thorough history from the patient and their relative, conducting a physical examination, the height and weight of the individual are also determined to find out the BMI of the individual. Physical assessment is only helpful in terms of determining the extent of physical damage done by anorexia nervosa. Physical investigations may include blood tests, x-rays, ultrasound scans and electrocardiograph. A hospital assessment reveals the weight reducing behaviors of an individual.

In individuals with diabetes, thyroid disease or inflammatory bowel disease the diagnosis becomes more challenging. In diabetes, patients who do not want to gain calories and may limit their use of insulin.

Anxiety, mood disorders and emotional problems are commonly associated with anorexia nervosa. With time these exacerbate as anorexia nervosa causes problems with the patient's social, academic and work life; damaging the patient's quality of life. When controlling their weight a patient feels they are in control of their lives but when they have lost that control they may feel like they have lost control of their lives and have lost their personal autonomy.

Herzog et al (1992) discovered that anorexia nervosa is comorbid with depression in 63 percent of individuals. Rastam (1992) have found that obsessive compulsive disorder and anorexia nervosa are found together in about 35 percent of the patients.

Physical affects of anorexia nervosa:

Almost all the systems of the body are affected by anorexia nervosa.

- The musculo-skeletal system – muscles become weak, there is bone density loss and increased risk of bone fracture – Lucas et al 1999
- Endocrine system
- Reproductive system
- Amenorrhea is a secondary affect of severely low BMI in women
- Teeth
- The brain – Loss of brain volume. Dolan at al (1988)

If weight is restored back to normal there is a recovery of the patient's cognitive problems. Executive functions of the brain however are not restored back to normal, Tchanturia et al (2001). Impaired cognitive functions can have damaging affects on the development of social relationships and work life.

Treatment:

Cognitive behavior therapy, interpersonal psychotherapy, focal psychodynamic therapy, cognitive analytic therapy, and family therapy focused on healthy eating are a few examples of therapies available to patients with anorexia nervosa. These aim to promote healthy eating in patients.

Prognosis:

Anorexia nervosa has a variable prognosis. A study conducted by Steinhausen (1993) showed that of the 68 individuals receiving treatment for anorexia nervosa, five percent passed away, forty three percent recovered fully, thirty six percent showed an improvement in their condition and twenty percent of the individuals developed a chronic eating condition. Long term studies conducted on the prognosis of individuals with anorexia nervosa have sown that mortality is often due to the physical damage done by starvation and also because of suicide.

Case Study:

Patient details: Name: SC, Age:16yrs

My write up was inspired by a case study I had come across during my placement. It was based on a patient who was diagnosed with eating disorder and anorexia nervosa and associated volatile mood disorder. The patient experienced irritability, impulsiveness, and outbursts of anger. The anger was most obvious in the presence of her parents, especially the father. She had been attending a special school for people with learning disabilities but on her recent examination of her IQ she scored 63 which is learning disability in the mild range. She scored in the seventies for her perceptual reasoning and working memory. During her assessment she was observed to have a poor attention span and this was attributed as one of the causes for her low IQ score. She does not have a low IQ as people with low IQ tend to score low in all sections of the IO test.

She was afraid of being fat and restricted her diet by skipping meals and using her will power to stop eating. She had been going to eating disorder services which helped her weight, but she continued to worry about getting fat.

She had a medical history epilepsy, hypochromic microcytic anaemia, irregular and short periods. She was on carbamazepine for her epilepsy and had no known family history of any medical conditions. She lived with her parents and her 25 year old brother. She was receiving counseling and family therapy for her medical condition.

The placement and especially my case study offered me an opprtunity to learn about a subject I had little knowlede but felt passionately about. Anorexia Nervosa is a complex medical condition requiring

careful feeding plan as well as psychotherapy. The treatments offered are tailored to a patient's needs. Sixty percent of anorexia nervosa sufferers are cured of their condition when they are offered medical treatment for their condition. A lot of anorexia nervosa sufferers are undiagnosed and this hinders offerring them the correct medical advice for their condition.

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