Anorexia Nervosa: A Literature Review

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Abstract: Weight loss has always been a point of worry amongst the females. Although the affected females go for emaciation which might also be linked as a part of good looks or beauty. As the world is now focusing on fitness, women having multiple factors in gaining weight tend to fall prey to eating disorders and body image disturbances. Out of all the genders women are commonly affected with Anorexia Nervosa hence, under this article, a review has been done on studies conducted on females affected with Anorexia Nervosa. The researchers have worked upon the factors like emaciation, body size estimation, effects on quality of life, emotional and behavioural changes, childhood risk factors, early detection of the disorder. The results in the following literatures have been an eye opener as how a disorder can affect wide aspects of women/ girl’s life. Some results from the studies showed that anxiety plays a major role in overestimation of body size in AN, whereas some samples demonstrate premorbid anxiety, perfectionism and emotional under eating as causative factors and others girls with anorexia nervosa were less satisfied about family environment and rated their families as less communicative, flexible, cohesive, and more disengaged, compared to controls.

Keywords: Anorexia nervosa, Emaciation, Body size estimation, Quality of life, Weight loss, Diabetes, Adolescents, Women.

1. Introduction

Weight loss has always been a point of worry amongst the females. Although the affected females go for emaciation which might also be linked as a part of good looks or beauty. Smith et al. studied to determine if females with Anorexia Nervosa (AN) associate emaciation with beauty by examining implicit attitudes toward emaciated bodies related to thin bodies. Thirty women with AN and 29 healthy control women were primed by viewing images of either emaciated or thin women. Participants then completed a lexical decision task (LDT), wherein they distinguished words from nonwords as quickly and accurately as possible. Response times were measured. Real words consisted of beautiful, ugly, neutral, and positive words. Body mass index (BMI) was measured and several clinical interviews were completed, including the Eating Disorders Examination Questionnaire 4 (EDEQ-4). There was a significant effect of group in the emaciated condition; participants with AN responded faster to both beautiful and ugly words than control women did. Eating disorder symptom severity (as measured by the EDEQ-4 subscales) predicted the strength of the association between emaciation and beauty. At an implicit, automatic level, women with AN in this study had stronger associations between emaciation and both beauty and ugliness than control women did, suggesting that women with AN may have atypical beliefs about beauty. Thin ideal internalization is an important factor in the development and maintenance of eating disorders; the type of thin ideal being internalized may be important to consider, particularly given the extent to which pro-eating disorder websites promote idealization of emaciation. The associations found by using the LDT highlight the utility of implicit measures, particularly when conducting assessments involving sensitive or atypical beliefs [1].

Överås et al. compared body size estimation based on memory versus perception, in patients with anorexia nervosa (AN) and healthy controls, adjusting for possible confounders. Seventy-one women (AN: 37, controls: 35), aged 14–29 years, were assessed with a computerized body size estimation morphing program. Information was gathered on depression, anxiety, time since last meal, weight and height. Results showed that patients overestimated their body size significantly more than controls, both in the memory and perception condition. Further, patients overestimated their body size significantly more when estimation was based on perception than memory. When controlling for anxiety, the difference between patients and controls no longer reached significance. None of the other confounders contributed significantly to the model. The results suggest that anxiety plays a role in overestimation of body size in AN. This finding might inform treatment, suggesting that more focus should be aimed at the underlying anxiety [2].

Patients affected with the disease undergo a lot of changes in their daily life. And the impact of the disease is an important area for study. Relating to this, Muñoz et al. conducted a study on the assessment, of the impact of eating disorders on quality of life using the disease-specific, health-related quality of life for eating disorders questionnaire. The study included 358 patients with eating disorder completed the health related quality of life for eating disorders questionnaire and the eating attitudes test. 273 patients completed the same instruments after 1 year of multidisciplinary treatment. The study concluded that Patients with anorexia nervosa had higher baseline scores (indicating worse perception of quality of life) on the health-related quality of life for eating disorders questionnaire and experienced smaller improvements than patients with other diagnoses after 1 year of treatment. Quality of life in patients with eating disorder improved after 1 year of treatment [3].
Considering the emotional and behavioural changes a patient goes through his stage of disease condition, Kyriacou et al. conducted a qualitative study on comparing views of patients, parents, and clinicians on emotions in anorexia. In this study patients with anorexia nervosa may experience difficulties in emotional processing that can adversely affect treatment and maintenance of the illness. Questionnaires were undertaken with patients with anorexia nervosa, parents and clinicians, with the aim to explore the most salient issues pertaining to emotions and social cognition in anorexia nervosa. The study concluded that seven primary themes were identified showing congruence across groups: emotional awareness and understanding, emotional intolerance, emotional avoidance, emotional expression and negative beliefs, extreme emotional responses, social interactions and relationships, and lack of empathy [4].

Considering the fact that women are majorly affected with Anorexia Nervosa a retrospective comparisons study was conducted by Kim et al., on childhood risk factors in Korean women with Anorexia Nervosa. The study included two sets of case-control comparisons, in which 52 women with lifetime anorexia nervosa from Seoul, S. Korea, were compared with 108 Korean healthy controls and also with 42 women with lifetime anorexia nervosa from the UK in terms of their childhood risk factors. A questionnaire designed to conduct a retrospective assessment of the childhood risk factors was administered to all participants. The study concluded that the Korean anorexia nervosa women were more likely to report premorbid anxiety, perfectionism, and emotional under eating and were less likely to report having supportive figures in their childhood than the Korean healthy controls [5].

Eating disorders affect more women than men. An early detection for the presence of eating disorders (EDs) and clinical findings in 20-25 years old women residing in professional college hostels in Bangalore city, India, Jugale et al. conducted a cross-sectional study. One hundred seventeen women of the 128 selected randomly participated in the study. SCOFF [Sick, Control, One-stone (14 lbs/6.5 kg), Fat, Food] Questionnaire was used for screening suspected cases of anorexia nervosa (AN) and bulimia nervosa (BN). Examination was done for systemic findings, extra-oral and intra-oral manifestations of EDs. Data obtained were analyzed using SPSS (version 13.0). The response rate was 71.3%, of which 42.7% were suspected to have EDs by SCOFF. Examination showed significantly higher prevalence of periomyolysis (p=0.004), dental caries (p=0.004), and tooth sensitivity (p=0.001) in suspected cases. The study succeeded at ‘case-finding’ of EDs with a significant prevalence of oral manifestations in suspected cases. Thus, dentists play a major role for early detection and prompt further referral of co-morbid disorders, like EDs [6].

Another study conducted by Laghi et al. aimed at examining whether adolescent girls diagnosed with anorexia nervosa and their parents differ in perceiving the different aspects of family functioning. Moreover, the discrepancy between adolescent girls and healthy controls on Family Adaptability and Cohesion Evaluation Scales dimensions, family communication, and family satisfaction was investigated. The study included 36 female anorexia patients and their parents and 36 healthy controls. The results showed a different view between mothers and their daughters with regard to the dimension of rigidity. In addition, girls with anorexia nervosa were less satisfied about family environment and rated their families as less communicative, flexible, cohesive, and more disengaged, compared to controls [7].

Amongst all the researches, another research by Thomson et al. aimed to investigate parents’ experiences of recognizing that their child had an eating problem and deciding to seek help. Adolescents with anorexia nervosa rarely present themselves as having a problem and are usually reliant on parents to recognise the problem and facilitate help-seeking. A qualitative study with interpretative phenomenological analysis applied to semi-structured interviews with eight parents of adolescents with a diagnosis of anorexia nervosa. Parents commonly attributed early signs of anorexia nervosa to normal adolescent development and they expected weight loss to be short-lived. As parents’ suspicions grew, close monitoring exposing their child’s secretive attempts to lose weight and the use of internet searches aided parental recognition of the problem. They avoided using the term anorexia as it made the problem seem ‘real’. Following serial unsuccessful attempts to effect change, parental fear for their child’s life triggered a desire for professional help. Parents require early advice and support to confirm their suspicions that their child might have anorexia nervosa. Since parents commonly approach the internet for guidance, improving awareness of useful and accurate websites could reduce delays in help-seeking [8].

Similarly, a cross-sectional study was conducted at higher secondary public school, by Hisam et al. at Rawalpindi from June 2013 till December 2013.To find out frequency of anorexia nervosa (AN) among teenage girls (TG) and to find out the knowledge and practice regarding anorexia nervosa among teenage girls. A sample of 100 female students of the age group 13-19 years were inducted by systematic sampling technique. Mixed pretested questionnaire was filled after informed verbal consent. Data was entered and analysed using SPSS version 20. Participants mean age was 15.81 ± 1.323 years. Mean weight, mean height and mean body mass index were found to be 50.34 ± 10.445 kg, 160.14 ± 7.846 cm and 19.675 ± 4.1477 kg/m2 respectively. Anorexia nervosa was found in 42 (42%) teenage girls while 58 (58%) were not having anorexia nervosa. Sufficient knowledge and positive practice were found to be present in 57 (57%) and 49 (49%) respectively. Statistically no significant association was found between KP and AN (p=0.73). Anorexia nervosa is an emerging health concern in Pakistan. Anorexia prevalent behaviour was observed in almost half of the teenage girls [9].

A study was conducted by Wentz et al., to study prospectively the long-term outcome and prognostic factors in a representative sample of people with teenage-onset anorexia.
nervosa. Fifty-one people with anorexia nervosa, recruited by community screening and with a mean age at onset of 14 years were compared with 51 matched comparison individuals at a mean age of 32 years (18 years after disorder onset). All participants had been examined at ages 16 years, 21 years and 24 years. They were interviewed for Axis I psychiatric disorders and overall outcome (Morgan–Russell assessment schedule and the Global Assessment of Functioning). There were no deaths. Twelve per cent (n=6) had a persisting eating disorder, including three with anorexia nervosa. Thirty-nine per cent of the anorexia nervosa group met the criteria for at least one psychiatric disorder. The general outcome was poor in 12%. One in four did not have paid employment owing to psychiatric problems. Poor outcome was predicted by premorbid obsessive–compulsive personality disorder, age at onset of anorexia nervosa and autistic traits. The 18-year outcome of teenage-onset anorexia nervosa is favourable in respect of mortality and persisting eating disorder [10].

Onset of anorexia nervosa prior to menarche is rarely encountered and little is known about clinical and psychological differences between this group and the more typical postmenarcheal patient. A cross-sectional investigation by Arnow et al. compared 26 premenarcheal patients with 69 patients with secondary amenorrhea. Menarchal status was confirmed with Tanner scaling obtained via pediatric examination. Duration of illness was equal among the groups. Differences between the groups included higher internal locus of control and need for approval through socially desirable control and need for approval through socially desirable respect of mortality and persisting eating disorder [10].

Disturbed eating and severe caloric restriction are characteristic features of patients with anorexia nervosa (AN). Despite the importance of eating behavior in the presentation of AN, there have been relatively few objective laboratory studies of eating behavior among persons with eating disorders. Hence, Robyn et al conducted a study on eating behaviour among women with AN to obtain objective measures of eating behavior among patients with AN before and immediately after weight restoration and to compare those measures with measures among control subjects. Twelve patients hospitalized for AN and 12 control subjects participated in the study. Eleven of the 12 patients were retested at 90% of ideal body weight. The average meal consumption was 103.97 ± 102.08 g for patients at low weight and 178.03 ± 202.97 g after weight restoration (NS). Control subjects consumed significantly more than did AN patient at both time points, and the average meal size was 489.58 ± 187.64 g. Patients showed significant decreases in psychological and eating-disordered symptoms after weight restoration. These data suggest that patients with AN show a persistent disturbance in eating behavior, despite the restoration of body weight and significant improvements in eating-disordered and psychological symptoms. [14].
2. Conclusion

This paper presented an overview on Anorexia Nervosa.

References


