ANOREXIA NERVOSA

Restricting type anorexia nervosa and binge-eating/purging type anorexia nervosa



INTRODUCTION

Anorexia nervosa is a psychiatric disorder belonging to the family of eating disorders. It is characterised by voluntary restriction of food intake leading to a significantly lower-than-expected body weight, an intense fear of gaining weight and an altered perception of the body. Contrary to what its name suggests, it does not correspond to a disappearance of appetite. Hunger is generally present but actively fought against. Restriction gradually becomes a way of adapting to internal tensions, at the cost of physical, psychological and relational consequences.

DSM-5 DIAGNOSTIC CRITERIA

1. Restriction of energy intake leading to a significantly low body weight for age, sex and development.
2. Intense fear of gaining weight or persistent behaviours that interfere with weight gain, despite being underweight.
3. Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation.

TWO CLINICAL TYPES

Restricting type: weight loss is primarily achieved through dieting, fasting and/or excessive exercise, without recurrent episodes of binge eating or purging behaviours during the past three months.

Binge-eating/purging type: recurrent episodes of binge eating and/or self-induced vomiting or purging behaviours during the past three months.

CLINICAL IDENTIFICATION

Physical: weight loss, fatigue, feeling cold, bradycardia, hypotension, digestive problems, hormonal disturbances, reduced body strength, dangerous electrolyte disturbances in purging forms.

Psychological: fear of gaining weight, body-image distortion, intrusive thoughts, perfectionism, anxiety, depressive symptoms and difficulty identifying emotions.

Relational: ritualised meals, avoidance, family tension, social withdrawal, worry and helplessness among relatives.

Clinical severity cannot be reduced to BMI: psychological, physical and relational impact must be assessed. The risk of death is estimated at 5 to 10% of cases.

ANOREXIA NERVOSA:
UNDERSTANDING AND SUPPORTING

Differential diagnosis

Medical assessment must rule out a physical cause of weight loss or food restriction, including endocrine, digestive, infectious, inflammatory or cancerous diseases.

Differential diagnosis also includes bulimia nervosa, binge-eating disorder, ARFID, major depressive episode, certain anxiety or obsessive-compulsive disorders, and psychotic disorders.

Anorexia nervosa is distinguished in particular by an excessively low body weight, an intense fear of gaining weight and an altered body image.

Multifactorial aetiopathogenic hypothesis

1. **Predisposing factors:** genetic vulnerabilities, perfectionism, anxiety, low concentration, attachment-related emotions, family environment and sociocultural contact.
2. **Triggering factors:** weight-loss dieting, puberty, stressful events, conflicts, traumatic experiences, comments about weight, and the influence of peers and social media.
3. **Maintaining factors:** malnutrition and its biological effects, cognitive and behavioural rigidification, reactions from those around the person, isolation and reinforcement of restrictive behaviours.

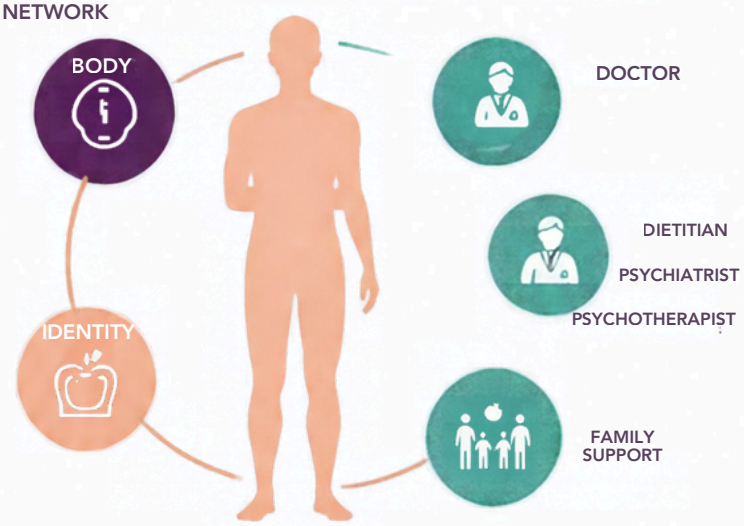
Gestalt perspective

The symptom may constitute a creative adjustment to developmental challenges: relationship to the body, construction of identity and the capacity to enter into relationship. The symptom represents an attempt, albeit a paradoxical one, to continue a movement of growth and maintain contact with the world when other possibilities for adjustment no longer make it possible to respond to challenges and uncertainty.

It becomes pathological when this adjustment becomes rigid and turns into a fixed form of contact. What initially constitutes an adaptive response becomes a unique, repetitive and increasingly costly mode of functioning. The rigidification of contact is also manifested in the functioning of the Self. The I-function gradually becomes predominant: control, choice and mastery occupy the foreground of experience, while sensations, needs and flexible emotion lose their vitality.

FROM THE RIGID CIRCLE TO THE CARE NETWORK

OPENING UP TO NEW POSSIBILITIES OF CONTACT



Care

1. Early identification and intervention.
2. Physical and psychiatric assessment.
3. Multidisciplinary care: doctor, psychiatrist, psychologist or psychotherapist, dietitian and family support.
4. Hospitalisation in the event of physical or psychiatric complications, suicidal risk, failure of outpatient care or inability to provide safe care.
5. Psychotherapies: CBT, family and multifamily therapies; Gestalt therapy works with present experience, the relationship, the sense of self and new possibilities of contact. No single approach addresses all dimensions of the disorder.

Therapeutic objective

Beyond weight restoration: regaining a freer relationship with the body, food, emotions and others. It is a long journey that Francesetti calls the 'road of courage'.