

Anorexia: Symptoms, Causes & Treatment Options

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Introduction and Definition of Anorexia Nervosa

Anorexia Nervosa (AN) represents a severe and complex psychiatric disorder characterized by a persistent restriction of energy intake leading to significantly low body weight, an intense fear of gaining weight or becoming fat, and a disturbance in the way one's body weight or shape is experienced. This condition is far more than a simple lifestyle choice or preoccupation with dieting; it is a life-threatening illness with the highest mortality rate among all psychiatric disorders, frequently due to medical complications stemming from starvation or suicide. The term **anorexia** literally means "loss of appetite," though this is a misnomer, as individuals suffering from AN typically experience hunger but actively suppress it through extraordinary self-control and often ritualistic behaviors. The core psychopathology lies in the relentless pursuit of thinness and the deep-seated inability to recognize the severity of their current low weight, a phenomenon often described as ego-syntonic, meaning the behaviors align with the patient's perceived values and goals.

The psychological profile associated with **Anorexia Nervosa** often involves pervasive feelings of ineffectiveness, excessive perfectionism, and a rigid, all-or-nothing thinking style. These traits frequently predate the onset of the eating disorder and contribute significantly to its maintenance. The restriction of food intake is commonly utilized as a maladaptive coping mechanism to manage internal distress, anxiety, and feelings of lack of control in other areas of life. As the illness progresses, the physiological effects of starvation--including cognitive impairment, mood disturbances, and increased obsessiveness--further solidify the pathological patterns, creating a vicious cycle that is extremely difficult to interrupt without specialized intervention. Understanding AN requires acknowledging the interplay between genetic predisposition, psychological vulnerabilities, and socio-cultural pressures that contribute to its development and persistence across the lifespan.

While AN typically manifests during adolescence, particularly in females, the prevalence is increasingly recognized across diverse age groups and genders. The clinical presentation is highly varied, ranging from subtle restrictive eating patterns to overt, severe malnutrition requiring immediate inpatient hospitalization. Early identification and intervention are paramount to improving prognosis, yet the secrecy and denial inherent to the disorder often delay treatment seeking. The enduring impact of AN extends beyond the physical body, severely disrupting educational attainment, professional functioning, and interpersonal relationships, demanding a comprehensive, multi-disciplinary approach that addresses both the immediate physical danger and the underlying psychological turmoil.

Historical Context and Prevalence

While **Anorexia Nervosa** gained widespread clinical recognition in the late 19th century, with

seminal descriptions provided independently by Sir William Gull in England and Charles Lasègue in France, historical accounts suggest similar conditions have existed for centuries. Medieval accounts of "holy anorectics" or ascetics, predominantly women who engaged in self-starvation for religious piety, illustrate a historical connection between food restriction and control, although the modern clinical understanding links the behavior primarily to body image and fear of weight gain rather than spiritual devotion. Gull's 1873 paper, which formally coined the term, established the illness as a distinct medical entity rooted in psychological disturbance, noting the patient's refusal to eat despite having access to food and lacking any apparent organic disease. This historical perspective highlights the evolving understanding of the etiology, shifting from purely physical ailments to complex biopsychosocial interactions.

In contemporary society, the prevalence of **Anorexia Nervosa** remains relatively stable but concerning. Lifetime prevalence estimates for women typically range between 0.3% and 1.0%, though subclinical eating disorders are far more common. The incidence rate is significantly higher in adolescent females, particularly those aged 15 to 19, an age group highly susceptible to developmental pressures and social comparison. While historically viewed as a disorder primarily affecting affluent white females, research has demonstrated that AN affects individuals across all socioeconomic strata, ethnicities, and cultural backgrounds, though presentation and help-seeking behaviors may vary. Critically, the diagnosis of AN in males, though less common (estimated at a 1:10 ratio compared to females), is often delayed due to societal misconceptions that eating disorders only affect women, leading to potentially worse outcomes due to prolonged illness duration prior to treatment.

The 20th and 21st centuries have witnessed significant shifts in the socio-cultural landscape that may contribute to the maintenance and visibility of AN. The pervasive influence of mass media, the relentless promotion of the "thin ideal," and the rise of digital platforms emphasizing appearance-focused content have amplified body dissatisfaction globally. While these factors are not direct causes of AN, they serve as powerful environmental triggers and maintaining factors, especially for genetically vulnerable individuals. Understanding prevalence requires careful consideration of diagnostic drift and the continuum of disordered eating behaviors, recognizing that the clinical threshold for AN represents the most severe manifestation of these restrictive and fear-driven psychological processes within a culture that often equates thinness with success and moral virtue.

DSM-5 Diagnostic Criteria

The current diagnostic framework for **Anorexia Nervosa** is outlined by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), which specifies three essential criteria that must be met for a clinical diagnosis. The first criterion is the restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. The term **significantly low**

weight is deliberately non-specific regarding a single numerical threshold like BMI, recognizing that what constitutes low weight must be individualized; for adults, a BMI below 17.0 kg/m² is often considered severely low, but the clinical judgment must account for the individual's normal weight range and the degree of deviation from that baseline. This criterion establishes the physiological necessity for diagnosis, differentiating AN from other mental illnesses where weight loss may be secondary.

The second core criterion involves an intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though the individual is currently at a significantly low weight. This fear is typically overwhelming and irrational, driving the restrictive behaviors. Individuals often employ highly detailed and complex strategies to avoid weight gain, including meticulous calorie counting, obsessive exercise routines, or avoidance of social situations involving food. This criterion highlights the psychological engine of the disorder: the phobic avoidance of normal or healthy weight. It is not merely the presence of low weight that defines AN, but the psychological preoccupation and active behavioral maintenance of that state, emphasizing the pathological motivation behind the caloric restriction.

The third and final criterion addresses the disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. This component captures the cognitive distortion central to **Anorexia Nervosa**, often referred to as body image disturbance. Patients frequently view themselves as overweight even when severely emaciated, and their self-worth is disproportionately tied to their physical appearance and ability to maintain control over their size. Furthermore, the lack of insight regarding the medical danger of their starvation prevents them from seeking or adhering to necessary treatment, posing a significant clinical challenge. The DSM-5 also specifies levels of severity--mild, moderate, severe, and extreme--based on the patient's current Body Mass Index (BMI), guiding the intensity of required medical monitoring and intervention.

Etiology: Biological, Psychological, and Socio-cultural Factors

The development of **Anorexia Nervosa** is rarely attributable to a single cause; rather, it emerges from a complex interplay of biological, psychological, and socio-cultural risk factors, often referred to as the biopsychosocial model. Biologically, genetic predisposition plays a substantial role, with twin studies estimating the heritability of AN to be between 50% and 70%. Individuals with a first-degree relative who has suffered from an eating disorder, depression, or anxiety disorder are at a significantly elevated risk. Neurobiological research suggests potential abnormalities in neurotransmitter systems, particularly those involving serotonin and dopamine, which regulate appetite, mood, and reward processing. For example, altered serotonin activity might contribute to the anxiety and obsessiveness seen in AN, while changes in dopamine pathways might influence

the reward derived from starvation and exercise, reinforcing the restrictive behaviors.

Psychological factors are critical vulnerability markers. Certain personality traits are consistently associated with the development of **Anorexia Nervosa**, including high levels of perfectionism, rigidity, neuroticism, and harm avoidance. Individuals with AN often exhibit an overwhelming need for control, which, when coupled with feelings of ineffectiveness or emotional dysregulation, can lead to the use of food restriction as a domain where mastery and control can be reliably achieved. Furthermore, a history of anxiety disorders, particularly separation anxiety or obsessive-compulsive disorder (OCD), frequently precedes the onset of AN. Trauma, chronic stress, or significant life transitions can also act as precipitating events, where the eating disorder behaviors serve as a dysfunctional mechanism to cope with overwhelming emotional pain or external chaos.

Socio-cultural influences provide the contextual framework within which AN manifests. The pervasive Western cultural emphasis on thinness as an ideal of beauty, success, and health exerts immense pressure, particularly on vulnerable adolescents. The internalization of the **thin ideal**--the degree to which an individual accepts and attempts to achieve this standard--is a powerful predictor of body dissatisfaction and subsequent disordered eating. Family dynamics, while not a direct cause, can also contribute to risk, particularly environments characterized by high expectations, emotional restraint, or over-involvement, though research now strongly emphasizes that family factors are often a consequence of coping with a severe illness rather than the initial cause. Ultimately, the etiology of AN is best conceptualized as a diathesis-stress model, where genetic and temperamental vulnerabilities interact with stressful environmental and cultural pressures to trigger the onset of the disorder.

Subtypes of Anorexia Nervosa

The DSM-5 recognizes two distinct subtypes of **Anorexia Nervosa**, differentiated based on the behavioral patterns displayed by the individual during the most recent three months of the illness. This distinction is clinically significant as it can influence treatment planning and prognosis, though both subtypes share the core features of significantly low body weight, intense fear of weight gain, and body image distortion. The first subtype is the **Restricting Type (AN-R)**, where weight loss is achieved primarily through dieting, fasting, and/or excessive exercise. Individuals with AN-R do not regularly engage in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). These individuals often demonstrate extreme discipline and control over their food intake, adhering to highly rigid and self-imposed rules about what, when, and how much they are allowed to consume, frequently exhibiting high levels of obsessive-compulsive traits related specifically to food and exercise.

The second subtype is the **Binge-Eating/Purging Type (AN-BP)**. In this presentation, the individual regularly engages in binge eating or purging behaviors. It is crucial to note that the

defining factor separating AN-BP from Bulimia Nervosa is the significantly low body weight; if the individual maintains a weight at or above minimally normal levels despite engaging in bingeing and purging, the diagnosis shifts to Bulimia Nervosa. The binge episodes associated with AN-BP are often subjective, meaning the individual perceives they have eaten a large amount of food, even if the actual quantity is objectively small, reflecting the heightened sensitivity and perception of loss of control characteristic of the disorder. Purging behaviors are used as a compensatory mechanism to counteract the perceived caloric intake, driven by the intense fear of weight gain.

While both subtypes share the severe medical risks associated with malnutrition, the psychological profiles and risks differ slightly. Individuals with the **Binge-Eating/Purging Type** tend to exhibit greater impulsivity, higher rates of substance abuse, and higher rates of co-morbid mood disorders and self-harming behaviors compared to those with the Restricting Type. Conversely, those with the Restricting Type are often characterized by more pronounced rigidity and internalized control. However, the subtypes are not immutable; individuals can transition between AN-R and AN-BP over the course of the illness, underscoring the dynamic nature of **Anorexia Nervosa** and the necessity for continuous clinical assessment and adaptation of treatment strategies. The existence of these subtypes highlights the varying behavioral pathways that lead to the same life-threatening state of starvation and psychological distress.

Physical and Psychological Consequences of Starvation

The prolonged state of malnutrition inherent to **Anorexia Nervosa** inflicts devastating damage across nearly every physiological system in the body, leading to a host of severe and potentially irreversible medical complications. Cardiovascular complications are among the most dangerous, as the body attempts to conserve energy by slowing the heart rate (bradycardia) and lowering blood pressure (hypotension). Severe electrolyte imbalances, particularly hypokalemia (low potassium), often resulting from purging behaviors, can precipitate fatal cardiac arrhythmias. Furthermore, the starvation state leads to muscle wasting, including atrophy of the heart muscle itself, significantly reducing cardiac output and increasing the risk of sudden cardiac death. The body's attempt to maintain core temperature often fails, resulting in chronic hypothermia, which further stresses the cardiovascular system and requires continuous medical monitoring.

Endocrine and skeletal systems are heavily impacted. In females, malnutrition often results in **amenorrhea** (cessation of menstruation) due to the suppression of the hypothalamic-pituitary-gonadal axis, which signals critical reproductive dysfunction. This hormonal suppression, coupled with low body fat and cortisol dysregulation, leads rapidly to decreased bone mineral density and the onset of severe osteoporosis, even in adolescents. This bone loss is often irreversible, leaving survivors highly vulnerable to fractures later in life. Gastrointestinal problems are also ubiquitous, including chronic constipation, delayed gastric emptying (gastroparesis), and general disruption of gut motility. In cases involving purging, chronic acid exposure can lead to erosion of dental enamel,

inflammation of the esophagus, and, in rare but catastrophic instances, esophageal rupture.

Psychologically, the effects of starvation compound the underlying psychopathology of **Anorexia Nervosa**. Malnutrition contributes significantly to cognitive impairment, including difficulty concentrating, poor memory, and rigid thinking, making psychological therapy challenging until weight restoration begins. Co-morbid psychological disorders are extremely common, with high rates of major depressive disorder, generalized anxiety disorder, and obsessive-compulsive disorder (OCD). The social isolation resulting from the secretive and restrictive nature of the illness further perpetuates the psychological distress, often leading to deep feelings of shame and hopelessness. The combination of medical instability and severe psychological distress accounts for the high suicide risk associated with AN, necessitating integrated medical and psychiatric care from the outset.

Treatment Modalities and Weight Restoration

Effective treatment for **Anorexia Nervosa** requires a comprehensive, staged approach that prioritizes immediate medical stabilization and weight restoration before addressing the underlying psychological drivers of the disorder. The initial goal of treatment is to interrupt the starvation cycle and achieve a safe, medically stable weight. For patients who are severely malnourished (e.g., BMI below 15 or rapid weight loss), inpatient hospitalization or residential treatment is mandatory to manage the high risks of refeeding syndrome--a potentially fatal shift in fluids and electrolytes that occurs when severely malnourished patients are aggressively refeed. Weight restoration must be carefully monitored and managed by a specialized medical team to ensure safety and gradual, consistent weight gain.

Once medically stable, psychological intervention forms the cornerstone of long-term recovery. For adolescents, **Family-Based Treatment (FBT)**, often referred to as the Maudsley approach, is the most robustly supported and empirically validated intervention. FBT involves empowering parents to take charge of the refeeding process at home, normalizing parental authority over meals, and utilizing the family environment to challenge the illness. For adults, the primary evidence-based psychological intervention is typically Enhanced Cognitive Behavioral Therapy (CBT-E), which is transdiagnostic and highly focused on identifying and modifying the core mechanisms maintaining the eating disorder, including body checking, restrictive eating rules, and the over-evaluation of shape and weight. Other specialized psychotherapies, such as Specialist Supportive Clinical Management (SSCM), may also be utilized based on individual patient needs.

Pharmacological interventions play a supporting, rather than primary, role in the treatment of **Anorexia Nervosa**. Unlike other psychiatric conditions, no medication has been found effective in treating the core symptoms of AN, such as the intense fear of weight gain or the drive for thinness, or in promoting weight gain. However, psychotropic medications, particularly selective serotonin

reuptake inhibitors (SSRIs), are frequently prescribed to manage co-morbid conditions like depression, anxiety, or obsessive-compulsive symptoms, which can significantly impede psychological recovery. The long-term success of treatment hinges upon the patient's commitment to sustained nutritional rehabilitation and the successful integration of psychological skills that allow them to manage distress and self-worth outside the context of body size and caloric control.

Prognosis and Long-Term Recovery

The prognosis for **Anorexia Nervosa** is highly variable, reflecting the severity and chronicity of the illness. AN is characterized by high rates of relapse and a protracted course of recovery for many individuals. Outcome studies suggest that approximately one-third of individuals achieve full recovery, one-third achieve partial recovery (meaning they maintain a healthy weight but continue to struggle with some disordered thoughts or behaviors), and one-third experience a chronic, relapsing course. Full recovery is often defined as maintaining a healthy weight for at least one year and being free of all eating disorder symptoms and psychological distress associated with the disorder. Early intervention, particularly in adolescence through FBT, is strongly correlated with better long-term outcomes and higher rates of full recovery compared to interventions initiated later in adulthood.

Factors associated with a poorer prognosis include a longer duration of illness prior to treatment, a lower nadir weight (the lowest weight achieved during the illness), the presence of co-morbid substance abuse or personality disorders, and late age of onset. Furthermore, individuals diagnosed with the **Binge-Eating/Purging Type** often have a more complex and difficult recovery trajectory compared to those with the Restricting Type, due to the increased prevalence of impulsivity and emotional dysregulation. Even after achieving weight restoration, individuals may continue to struggle with residual symptoms, such as body image dissatisfaction, elevated anxiety, and perfectionistic tendencies, necessitating long-term follow-up care and support to prevent relapse, which is particularly common during the first year post-discharge from intensive treatment.

Ultimately, recovery from **Anorexia Nervosa** is a multi-year process that extends far beyond the physical achievement of a healthy weight. It involves profound psychological shifts, including separating self-worth from body size, developing healthy emotional regulation skills, and overcoming the deeply ingrained fear of food and weight gain. The high mortality rate associated with AN--significantly elevated compared to the general population--underscores the need for continuous public health awareness, improved screening, and specialized resources. While full recovery is challenging, it is absolutely achievable, emphasizing the importance of specialized, evidence-based care delivered by experienced multidisciplinary teams committed to supporting the patient through the rigorous journey toward health and psychological freedom.