Abstract
Anorexia Nervosa is a tendency of eating minimal amount of food in order to avoid weight gain. It is included in what we call Eating Disorders. Anorexia is considered as an illness that has to do with low self-esteem often with tremendous desire to control their surroundings and emotions. This article describes anorexia Nervosa and it discusses the role that school counselors could play in the school setting., since they are in daily contact with the highest risk group for developing eating disorders—children and adolescents.

Keywords: Anorexia nervosa, school counselor role with anorexic students

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Anorexia Nervosa

Definition
Anorexia Nervosa is a tendency of eating minimal amount of food in order to avoid weight gain. It is included in what we call Eating Disorders. Anorexia is considered as an illness that has to do with low self-esteem often with tremendous desire to control their surroundings and emotions. It is unique reaction of external and internal conflicts such as stress, anxiety, unhappiness and a feeling that life is under no control. They often feel that is the only part of their life over which they can exercise any sort of control, though it ends up in the absurdity of feeling that every bit is an act of losing control (Berkman N., Lohr K., & Bulik C., 2007). It is all about having a massive fear of gaining weight and becoming fat. They are afraid of losing control over the amount of food they eat, linked with the desire to control their emotions and reactions to their emotions. With a desire to be accepted by their loved ones and society they engage in excessive dieting or starvation. Some also feel like they do not deserve to have pleasure, depriving themselves from situations that offer enjoyment, including eating. Here are two subcategories of Anorexia Nervosa in the DSM IV (Wonderlich S., Crosby R., Mitchell J., & Engel S., 2007).

- Restrictive Type (eating minimal amount of food)
- Binge-Purge Type

Epidemiology
Anorexics deny hunger, make excuses to avoid eating, will hide food and claim that they have eaten. About 90% of females suffer from Anorexia Nervosa and only 10% of males. Due to this factor, males are often overlooked and become untreated. The average prevalence of anorexia has been reported to be 0.3% epidemiological studies reveal that the peak age of onset is between 15 and 19 years old (Bulik C., Reba L., Siega-Riz A., & Reichborn-Kjennerud T., 2005).

Etiology of Anorexia Nervosa
Both social and psychological factors are probably important in the etiology of eating disorders. I believe that eating disorders result from the sociocultural demand for thinness in females, which produces a preoccupation with weight. Some believe that eating disorders are a culture-bound syndrome that is only found in western cultures. Society's increasing emphasis on this illness over the last twenty years is related to the increasing incidence of eating disorders.

Young women without eating disorders display a high degree of body dissatisfaction that is disturbing. Many women have a distorted body image. They over-estimate the size of their waist, thighs, and hips to a much greater extent than men do. A preoccupation with thinness appears to develop by early adolescence. A study of found that girls wanted thinner bodies than they thought boys found attractive. They did not consider themselves overweight, however, and displayed less body dissatisfaction than
older women. Women in their twenties have a much higher standard of thinness than girls do. This might indicate that a need to be increasingly thin begins to develop in adolescence and becomes deeply ingrained when the young woman reaches full adulthood. Especially intriguing is the finding by that adolescent girls were aware that their 'ideal' body shape was thinner than the body shape they thought boys found attractive.

**Clinical Characteristics**

Anorectics lose their appetites, as they fear gaining weight. They refuse to eat enough to maintain minimal weight, and have an intense fear of becoming obese. The manic energy expended in expended in excessive physical activity is amazing, considering their emaciation.

Amenorrhea, failure to menstruate regularly, is a characteristic feature of anorexia nervosa, often starting before weight loss has become noticeable. Physiological changes include dry, cracking skin, fine downy hair on the face and neck, brittle fingernails, yellowish discoloration of the skin, increase heart rate, constipation, reduced body temperature, and muscular weakness (Bulik, C. et al., 2005).

Some anorectics are preoccupied with food, even when they are struggling not to ingest it. They become interested in its preparation, collecting cookbooks, trying new recipes and planning and cooking elaborate meals of many courses and special dishes for others. Many anorectics do not admit to feeling hunger, but others say they do feel hungry but force themselves not to eat. Anorectics in general deny having any problem that needs treatment. Often they are described as polite, well behaved, conscientious, quiet, and often perfectionists. Anorectic patients often carry food with them or hide food around the house, yet may dispose of food in their napkins or hide it in their pockets when they eat with others.

Un intense fear of gaining weight and becoming obese is the predominant psychological disturbance. Others include obsessive-compulsive behavior, anxiety, somatic complaints, depression, sleep disturbance, suicide attempts. Also hypothermia occurs with profound weight loss, as may edema, bradycardia, hypertension, and lanugo (Bulik, C. et al., 2005).

**DSM-IV Diagnostic Criteria For Anorexia Nervosa**

A. Refusal to maintain body weight at or above a minimally weight for age and height (e.g., weight loss leading to maintenance of body weight Jess than 85% of that expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat even though underweight.

C. Disturbance in the way in which one's body weight and shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
D. In postmenarcheal females, amenorrhea, i.e. the absence of at least three consecutive menstrual cycles. (American Psychiatric Association., 2013)

The anorectic person
The anorectic is not capable of revering to a maintenance diet at the goal weight and will continue to diet after the societal reward has ceased because of her or his skeletal look. Nevertheless, the anorectic continues to be aware only of this pursuit of societal reward as reason for starving herself. It will haunt the anorectic throughout her illness, sometimes throughout life, and is typically expressed her fear of getting fat whenever she eats. Also the anorexics appear to suffer from poor self-esteem. If one takes a careful history, one always says finds states of serious depression and distress in anorexics prior to dieting. Often going on for years and associated with anxiety, worry and low self-esteem, depression and distress are states of no reward that cause the pre-anorectic to cry out for something that will make her feel less depressed and balance her mood. Instead of a socially available drug she chooses dieting because of its social acceptability. Thus, dieting as an avenue to positive feeling state constitutes the first motive to underestimate the severity and duration of the underlying distress and depression that resulted in the decision to diet (Gatward, N., 2007).

The daily reduction of food intake below maintenance requirements causes the body to switch to starvation mode by stimulating endorphin secretion. The physical condition under which this mechanism is triggered appears to be a switch by the body from burning carbohydrates to the use of fat stored in fat cells and does not depend on the person's weight. As designed by nature, endorphins stimulation seems to serve as a master switch, causing most, if not all-adaptational changes of the body and mind. Most important among the mental changes is the protection of the starving organism from the effects of starvation by providing heightened coping power and a reduction of suffering. Therefore, strictly speaking, endorphins were designed to be a reward -a substance that simply gives pleasing feelings. The defense is a mechanism of denial and is not always solid, and requires the help of other defenses. Therefore, it is not surprising that she resorts to lying, cheating, or secretly pursuing her anorectic activities despite strict prohibitions (Vandereycken, W., 2006).

The development of a distorted perception of body weight and appearance is a fact. The anorectic continues to lose weight and is close to emaciation. Nevertheless, she insists that her body looks normal to her. The anorectic may not continue her or his addictive behavior if she were aware of how far she has strayed from society's and her former standards. Therefore, causes the anorectic to develop new forms. Body image has been one of the most researched features of anorexia nervosa. It is not a cause, but a result of starvation and the subsequent
addictive dependence on starvation (Vandereycken, W., 2006).

Anorexia nervosa is a very serious illness that must be treated because it could be fatal for the patient. It is a potentially life-threatening disorder, with mortality rates of approximately 5% per decade of illness (Bulik, C. et al., 2005).

Anorexia Nervosa is a terrible, life threatening eating disorder that affects many young women and men. It shatters their inner and outer world and has serious complications in their life early intervention is crucial to recovery. Early treatment may be the best way to prevent the disorder from progressing.

**Anorexia Nervosa Treatment**

When a person's health is at risk, early intervention is crucial to recovery. Early intervention efforts attempt to identify individuals at the beginning stages of developing an eating disorder and are intended to prevent the development of more serious symptomatology. There is a greater chance for an individual to recover completely from an eating disorder if significant others intervene to combat the illness as early as possible.

Parents and friends of those who suffer from anorexia nervosa may play important healing factor if they could be included in the therapeutic process. They can help through their emotional support, creating family intimacy, and recognizing the individual’s needs. In order for this to work, therapy with anorexics and parents must be flexible, creative, and focus on system-wide healing processes.

The main treatment is psychological involving cognitive behavior therapy, supportive psychotherapy, counseling about eating and potentially dangerous methods of losing weight, and when appropriate, other psychological support such as relaxation, family therapy, hypnotherapy and so on (Fairburn, C. G., 2004). Such treatment as drug therapy should not be used for a particular long time as they do not allow patients to learn or relearn normal eating behavior and they often cause feelings of loss of control, and panic. Drugs (anti-depressants or antipsychotic drugs) are rarely necessary but they may be needed for example if a patient is clinically depressed or has an Obsessive Compulsive Disorder (Attia & Schroeder, 2004).

One of the most crucial points is a continuous support and control provided by relatives and therapists. Anorexia Nervosa patients are individuals. They have different problems, different needs, and are at different stages of their illness when they come for treatment by a person who can offer sympathetic understanding and individual treatment. Family therapy is commonly recommended as treatment of eating disorders among adolescent populations (Lock, J. & Grange, D., 2004). Since the child or adolescent could resist parental efforts to eat in order to fight parental authority. During the family therapy parents are coached how to avoid of making demands, express anger by blaming their child for anorexia. Family therapy is based on the systemic theory, which
understands the family to be living, organism that is more than the sum of its individual members. Problems are treated by changing the way the system works than trying to treat a specific member (Lock & Grange, 2004).

**School counsellor role**

School counselors are in daily contact with the highest risk group for developing eating disorders—children and adolescents. School counselors are in a position to identify at-risk individuals, implement effective school-based prevention programs, make appropriate referrals, and provide support for recovering individuals. An overview of a theory of recovery for eating disorders reinforces the importance of early intervention so, School counselors could play a critical role in assisting students either at-risk or currently battling an eating disorder. From their special position, School counselors can provide important services to students, parents, teachers, coaches, and community members that include: identification, referral, psychoeducation, and at-school support services. In fact, due to their direct contact with students in the peak modal age group, school counselors remain in the position to play an active and critical role in the prevention and early identification of eating disorders among the students’ population.

According to Bardick, Bernes, McCulloch, Witko, Spriddle, and Roest (2004), school counselors are in a position to provide early intervention by recognizing at-risk individuals, implementing effective school-based prevention programs, making appropriate referrals, and proving support for students recovering from eating disorders. Teenager students usually do not seek help but exhibit behaviors associated with dissatisfaction with weight and body shape and basically the responsibility to identify them in the school context lies to the school counselor.

School counselors should be vigilant of the warning signs and symptoms. In conjunction with teachers, school counselors identify individuals in the early stages of an eating disorder although they have to be aware of the warning signs in order to detect them. Peaslee (2006) lists the warning signs adolescents who could be in great danger to be anorexic. More specifically, the warning signs of anorexia nervosa are loss of menstrual period; dieting obsessively when not overweight; complaining of "feeling fat," when overweight is not a reality; preoccupation with food, calories, nutrition, and/or cooking; denial of hunger; excessive exercising; frequent weighing; strange food-related behaviors; episodes of binge-eating; rapid weight loss; weighs fifteen percent or more below normal body weight; wearing oversized clothing (due to thinking that one requires that size or having a desire to hide one's body); excess intake of low-fat or "healthy" foods (e.g., diet drinks, protein shakes, energy bars, herbal or nutritional supplements); counting calories and fat grams; vegetarianism; fasting; obsessive rumination about food; skipping meals or refusing to eat; avoiding food in social situations depression; and low self-esteem; mood
swings; an inability to express emotions, and demonstration of "black-and-white" thinking; slowness of thoughts/memory difficulties, and hair loss. With anorexics, social functions are avoided because the person feels fat and is afraid of what food will be served. They believe that everyone is focused on their weight as much as that they are, refuse to eat regular meals, and choose to 'nibble' throughout the day. A combination of these symptom/warning signs should be considered serious, and it is important that it is reported to the school’s physician-doctor. So it is crucial for the school counselors to be trained in order to be able to recognize the above symptoms and take immediate actions. Knowing the early signs and seeking immediate treatment can help prevent complications of anorexia. After identification, early intervention is necessary to prevent the development of more severe and serious symptoms.

When working with an at-risk adolescent, it is very important for school counselors demonstrate support, concern, express empathy and understanding, and to be honest, by creating a positive, non-judgmental, non-teaching relationship and by expressing acceptance, security and confidentiality. If honest statements are made from a person who cares, and those concerns reach the individual, than the journey to recover may begin (Bardick et al., 2004). The following nonjudgmental, empathetic, and truthful statements may be useful when approaching an anorexic student. Difficulties arise when the problem has been hidden for a long period. Individuals with eating disorders have a strong tendency to deny that there is a problem, to resist treatment efforts, and to insist that their behavior is legitimate and necessary. The school counselor should explain to the student, from the beginning of their counseling relationship that he or she is obliged to break confidentiality in cases where there is danger for the life/health of the student or someone else's life, and that, in such case the school counselor is obliged to inform the school administration and the parent/guardian. Demonstrating support and concern, expressing empathy and understanding, and telling the truth are three important factors to remember when confronting an at-risk individual. Expressing concern for a child's health and well-being to the parents, begins with honest, objective statements defining the behaviors of concern followed by insisting on obtaining the opinion of a trained professional. Unfortunately, denial is often the first reaction to expect when an individual with a potential eating disorder is confronted. When an eating disordered individual is first confronted about his or her condition, denial and resistance frequently are inevitable. The individual may insist that everything is fine and that his or her weight loss is rational and/or necessary. Symptoms may be defended out of fear and helplessness because the possibility of gaining weight during treatment is extremely threatening. Starvation also makes it difficult for individuals with an eating disorder to rationally appraise their condition. School
counselors need to recognize that denial and/or resistance is not directed against them. It is directed against the fear of irreversible weight gain, losing control, feelings of helplessness, and fear of change. Knowing that denial will likely be the individual's first response when initially confronted should not stop a concerned adult from expressing concerns to the student, and his or her parents, as well as referring the individual to a professional trained in the assessment and treatment of eating disorders. Significant others need to take the responsibility for treatment away from individuals under the age of 18 because the effects of starvation may render them unable to make decisions concerning their health and well-being.

This responsibility may begin with a school based resource person and in that case is the school counselor. A school-based eating disorder resource person, as the school counselor is, should have names and phone numbers of eating disorder specialists at his or her immediate disposal to ensure that the at-risk individual has access to appropriate help. A local hospital or mental health facility may be an excellent reference for obtaining the names and phone numbers of local specialists. Referral for specialized treatment is important because often a treatment team is required to address the multifaceted nature of an eating disorder. The treatment team may involve a medical doctor, a nutritionist, a mental health professional (i.e., psychologist or psychiatrist) who specializes in eating disorders, and/or a family therapist. Together, the treatment team will make decisions about assessment, treatment options.

Referring an at-risk individual to professionals who are capable of assessing and treating eating disorders is essential to beginning the recovery process. The school counselor should inform parents about the student and indicate specific events and behaviors that have noticed and which have alarmed the aim is to sensitize parents about these behaviors and how dangerous it can be done (e.g. " worry too much about the student after noticed that greatly increased exercise and not eating at all the breaks ") and must encourage them to seek help from experts. Suggesting a consultation or assessment (e.g., "I am concerned about your/your child's health and well-being and recommend further assessment by a professional"). Treatment of an eating disorder may be beyond the capabilities of school personnel, and therefore a school counselor's responsibility lies in working with the family to make a referral for assessment and treatment.

If parents feel that their child will not accept help, then the school counselor should urge and instruct them to seek help themselves and gives information for Therapeutic Center of Eating Disorder at Makarios III Hospital, in Nicosia. Additionally, he or she should explain to parents the need for completing the Referral form by him or her. If parents / guardians do not wish to follow the referral procedure through school, the counselor should advise them that they may themselves be addressed directly to Therapeutic
Center of Eating Disorder at Makarios III Hospital, in Nicosia. Of course, if parents / guardians prefer to work with the private sector, the school counselor should highlight the need of collaboration with a multi-disciplinary team of experts specialized in Eating Disorders. At any case, the school should have an ongoing cooperation with the therapeutic team throughout the duration of treatment and attendance of the student at school. Additionally, the school counselor is necessary to arrange a pedagogical meeting with the rest of the school’s teaching staff in order to present the rest of the education school personnel the basic knowledge they need to have in order to identify students at risk and refer them to the school counselor or to the school doctor. It is necessary for all staff to know the protocol and referral procedure of students with eating disorders. Presentation and training on eating disorders should be organized by the school counselor and should include all teachers of the school. Also, the school counselor should recommend that the requirements of the student to be within reasonable limits, be flexible with deadlines and workload placed upon it and offer the student alternative days for exams when they coincide with days that will its scheduled therapeutic meetings at the Therapeutic Center of Eating Disorders at Makarios III Hospital. The school counselors advise all teachers to offer alternatives to the program staff of the student who is in crisis and is receiving treatment. Moreover he or she advises them to show leniency when evaluating student and generally be very careful in any comments regarding the student because of the situation that requires great sensitivity. Throughout the student’s treatment, the school counselor, in cooperation with the school’s psychologist, will offer psychological support to the student. Summarizing, from the beginning of the school year it is very important, the School counselors to educate parents, teachers, coaches, and community members in order to raise their awareness of the signs and symptoms of eating disorders and the prevalence rates in the student population. For this purpose he or she could invite guest speakers to the school in order to discuss eating disorders, the risks, or harmful effects using a vast number of resources from the community in order to help create awareness of eating disorders. School counselors could also try to create and implement a school-based program that in order to discuss the dangers of dieting, the media and its influences on the ideal body image, and discuss the coping mechanisms for stress problems. School-based programs are generally an efficient and effective approach to battling eating and body image problems and implemented in the school context. School counselors possess a critical knowledge base that can be incorporated into parent education programs and parent/teacher association presentations. The school counselor would be the school-based resource person and his or her presence will alleviate any difficulties among the rest of the school personnel, of not knowing what to do when a student
seems to face an eating disorder. The school counselor is the appropriate professional will be always ready to dedicate extra effort and time to addressing these problems since he or she has an understanding of how to confront the at-risk individual, discuss concerns with parents, inform the rest of the school personnel and make a referral to an appropriate professional. School counselors may monitor their students' progress in referred treatment as well as provide at school support for those students in outpatient counseling. School counselors can also assist by offering group counseling opportunities for at-risk or diagnosed students. An awareness of diagnostic criteria, medical complications, causes, warning signs, and risk factors is crucial for school counselors; however, knowing what to do when faced with an individual at-risk for developing an eating disorder is very important and critical for the student’s eating disorder prognosis and treatment.

**Conclusions**

Eating disorders threaten the wellbeing of the young. Education and awareness needs to take place. They should be aware of eating disorders and the warning signs for early detection and intervention. Not only should adolescents be aware of the components of eating disorders; but also parents, teachers, school counselors, and other adults. These adults are the ones who are most likely to recognize the symptoms by seeing a change of behaviors and attitudes in adolescents. Early detection of the warning signs and symptoms is critical for battling eating and body image problems and preserving the psychological and medical health of all adolescents.

**References**


International Journal of Eating Disorders, 37, S26-30


