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Chapter Eight

1. Munchausen syndrome is also known as a factitious disorder. This disorder entails that the individual intentionally “fakes” physical symptoms in order to fulfill this inner wish to be a patient. The name “Munchausen” derives from a particular individual named Baron Munchausen. He was a cavalry officer who went around Europe telling others about fantastical military adventures that never really ever occurred. The extent at which individuals with factitious disorder is vast, where they intentionally take medication to induce certain symptoms of a disorder. For example, there’s one case where one may take anticoagulants to induce bleeding, another case where one may take laxatives to induce diarrhea, and another case to induce prolonged high fever. Individuals with factitious disorder go beyond the extent to follow through painful/costly treatment, therapy, and surgery. Individuals who are prone to developing this disorder are individuals who may have received long term treatment as a child, carried a grudge against healthcare, or those who have directly worked in the healthcare system. In addition, they have poor social/familial support.

2. Conversion disorder is when an individual clearly displays physical symptoms that affect voluntary motor or sensory function, but are not aligned with a known medical disease. The symptoms experienced are associated with the nervous system, like paralysis, paresthesia, or

blindness – but have no trace or root to a neurological disorder. Somatic symptom disorder are individuals who experience normal bodily effects, but are excessively distressed or anxious about the symptom at hand. They physically experience long lasting physical ailments, but again – have no root cause to a physical illness. They are very similar in the way both disorders are psychological, and the source of the disorder can be unknown. The main difference between conversion disorder and somatic symptom disorder is the fact that conversion disorder evidently displays neurological symptoms, whereas somatic symptom disorder has more to do with general signs/symptoms and the associated distress.

11. Relaxation training is self explanatory in its name – individuals are trained to relax their muscles by choice and through intentional thought. Through this, they reduce feelings of anxiety through relaxation training. Relaxation training has been proven to be effective in many disease processes. For example, this training is usually used in adjunct with medication to treat high blood pressure. Although relaxation and hypertension can seem unrelated, stress can chronically increase one's blood pressure. Therefore, relaxation can be essential in reducing hypertension. Relaxation training is also highly effective with headaches, insomnia, asthma, diabetes, pain after surgery, vascular diseases, and adverse effects with cancer treatments.

13. Biofeedback training is the patient's connection to diagnostic machinery that gives continuous reading about involuntary mechanisms in the body. The continuous readings about one's involuntary mechanisms give an individual greater awareness, and the information enables voluntary control over certain mechanisms. This biofeedback training has been proven to also be effective with patients that have anxiety disorders. For example, with a study that involved the

use of an electromyograph – a machine that detects muscle contractions. The study involved 16 patients with facial pain caused by tension in their jaw muscles. The EMG machine was attached to each individual's jaw muscles, and if a muscle contraction was detected, the contraction converted to a certain tone for the individual to recognize. The changes of the tone related to the degree of contraction in the muscles. The individuals were continually exposed to the tone, and eventually learned how to relax the muscles of the jaw – and reported less facial pain.

Chapter Nine

18. Individuals with bulimia nervosa stem from the same root of it being an eating disorder. With bulimia nervosa, the individual enters a vicious cycle of binging and purging. The individual "gives in" to eating all the foods that are "restricted" in their mind. During this time they overeat in any and every food that they desire – and usually during the binging, the individual usually states that they lost control. After they finish binge eating, the guilt of the calories begin to seep into their minds. At this point, they enter a time of purging. In individuals with bulimia nervosa, purging often looks like self inducing an episode of vomit to get "rid" of the calories. Purging could also look like extreme exercise to "undo" the calories that the individual ate. This cycle usually continues and exacerbates with the intensity of the disorder.

19. The similarities between anorexia nervosa and bulimia is the fundamental fact that both are rooted in disfigured body image, and the extreme unhealthy desire to want to be thin. Furthermore, the constant body dysmorphia intensifies the extent of the disorder. The main difference between the two disorders is the fact that bulimia nervosa follows a cyclic type of pattern, whereas anorexia nervosa follows a more intensifying pattern. As mentioned earlier with

bulimia, there is a purging and binging cycle. The individual consumes a large amount of food, and follows a self induced vomiting episode. However, with anorexia nervosa – the person is continually in a purging period of time with worsening restrictions. First, it may begin with the restriction of 1200 calories, but over time with worsening body dysmorphia, they may restrict down to 1000 calories, 500 calories, 100 calories, and come to an extremely fragile state.

26. The treatment for anorexia is oftentimes successful given that the individual follows through with the complicated recovery process. However, on the other hand – around 25 percent of individuals with anorexia remain heavily troubled with their relationship with food even after recovery. In addition, even if someone seeks treatment, they are susceptible to relapse if not properly managed. In terms of long term adjustment, the individual has to be aligned with the goals that treatment will regain their lost weight, recover from malnutrition, and have to get used to eating in a normal habit again. The treatment plan will be a combination of both psychological and physical treatment. In extreme cases that threaten multi-organ failure, the patient is subjected to tube and intravenous feeding. The individual may be highly resistant to eating again, thus different measures have to be taken in order to restore nutritional status. The physical treatment involves gradually increasing the patient's diet to more than 3000 calories a day. The diet is also coupled with supportive nursing care, and nutritional counseling. Psychologically, the individual has to get to the root of the underlying psychological issue that triggered the beginning of the disorder. Therapy would include cognitive-behavioral therapy, to break down and change the old, unhealthy behaviors and thought processes.

33. I believe that the underlying cause of David's eating disorder was the social beauty standard for men. David described wanting to reach a goal of 0% body fat, in order to achieve the "washboard abs" that other men had. I believe the incidence of eating disorders increased significantly in the last 50 years due to the expanding media that projects the beauty standard. For example, impressionable children are now being exposed to social media at an increasingly younger age. In addition, with the growth of the "influencers", more individuals are being projected to want to maintain or reach the beauty standard. Furthermore, I believe that there are privileges that are granted if you fit the beauty standard more than any time period than now. I believe that eating disorders are more common among women as opposed to men because of the difference in the standard. It is more common of the beauty standard to be thin for women, whereas it is usually a bigger/muscular figure for men.