

## ANOREXIA FOLLOWING TERMINATION OF PREGNANCY AND LAPROSCOPIC STERILIZATION

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### ABSTRACT

*Presentations of Anorexia Nervosa in India are usually atypical and anorexia is more commonly a symptom rather than a syndrome. This report highlights a case of anorexia following medical termination of pregnancy and laproscopic sterilisation, its association with conflicts regarding childbirth and motherhood in a 34 year old woman and the impact of anorexia on child rearing.*

*Key words : Anorexia, sterilization, pregnancy*

In women, Anorexia Nervosa typically begins during adolescence or early adulthood. However, there are a few reports of later age of onset with occurrence following childbirth and in association with termination of pregnancy (Thomas and Brian, 1982; Brinch et al., 1988).

It has been speculated that Anorexia, in association with childbirth is a result of conflicts in coping with the parental role and disturbances in body image, both during pregnancy and in the postpartum period. Onset of Anorexia Nervosa during this period has implications on motherhood and on the health of the child. Brinch et al. (1988), in their study on Anorexia Nervosa and motherhood, noted that 7% of anorectic mothers felt they had managed poorly as mothers, with 28% of children having either eating, nutritional or weight problems. Bhatia et al. (1988) and Chowdhary et al. (1999) have studied psychiatric morbidity in Indian women following sterilization procedures and found depression and somatisation to be the commonest problems. However, no published reports are available regarding post sterilization eating disorders in these studies or from other countries (Tang and Chung, 1997).

Khandelwal and Saxena (1990) and Chandra et al. (1995), have reported that

anorexia in India commonly occurs as a symptom rather than a syndrome, the presentation being usually atypical and often a manifestation of family pathology.

The following case illustrates several aspects of cross cultural and clinical interest, such as the atypical manifestation of Anorexia Nervosa in the Indian context, the association of anorexia with conflicts related to pregnancy and sterilization and the impact of anorexia in the mother on children.

### CASE REPORT

Mrs. S.; a 34 year old married woman was referred by a physician who was treating her for severe malnutrition. She presented with a four year history of reduced appetite, severe weight loss (>20 kgs) and avoidance of various types of food such as cereals, pulses and specific vegetables. She would give different reasons for avoiding these foods, specifically related to cultural notions of some foods causing heat in the body. Consequently, she was consuming predominantly fluids and in the last one year was drinking only a particular brand of oral rehydration solution with very little solids. The onset of the eating problem, which she attributed to a faulty sterilization operation, was about a week

following a medical termination of pregnancy and laproscopic sterilization. She started feeling progressively weak and was completely bedridden for eleven months prior to her psychiatric consultation. She was unable to perform any of her daily chores and her social and occupational functioning was severely impaired.

She also met ICD-10 criteria for moderate depression for 3 months prior to admission. Premorbidly, she was an individual with high achievement needs, marked health anxiety and several food fads. During her nine years of marriage she underwent medical termination of undesired pregnancies thrice, and had two children by normal vaginal deliveries. Her earlier pregnancies and postpartum periods were uneventful. Her youngest child at the onset of the eating disorder was one year old. With her children she was very particular about the food they ate, timing of meals and prevented them from eating certain types of food which she considered unhealthy which resulted in nutritional problems. Family assessment revealed marital disharmony and long standing conflicts with her mother in law. The patient also reported a sense of helplessness and frustration because of her frequent pregnancies, refusal by the husband to use contraception and repeated medical termination of unwanted pregnancies.

At admission her body weight was 31 kg. Her Quetelet's Body Mass Index was 16.9. She was emaciated and had several signs of severe malnutrition. However she continued to have normal menstrual periods

Investigations revealed dimorphic anaemia and ultrasonogram of the abdomen revealed multiple gallstones and renal calculi. She denied any fear of fatness or a need to become thin. A diagnosis of Eating Disorder NOS was made based on ICD-10 criteria.

The patient was treated with nutritional supplements, parenteral multivitamins and Imipramine upto a dose of 125 mg daily. Her depression improved rapidly but her anorexia persisted despite the improvement in her mood. She was noted to consume oral rehydration fluids

secretly in the ward despite instructions to the contrary and refused solid foods. Individual psychotherapy and marital therapy were initiated in the ward with nutritional counselling. The therapy focussed on conflicts in the marital dyad, particularly the patient's anger at having no control over her childbearing and her husband's insensitivity about it. Over a period of three weeks she gained 4 kg and at the time of discharge six weeks after admission she had markedly improved in her nutritional status and activities of daily living.

At follow up one year later, she weighs 46 kg and has been consuming adequate food though she continues to have some food fads. Her occupational and social functioning is adequate. She has been caring for her children who now have no nutritional problems.

## **DISCUSSION**

Anorexia Nervosa developing in the postpartum period and in women with young children has implications for the well being of the mother and the child. In our case, the patient developed anorectic symptoms during her third abortion and the presence of eating disorder had significant effects on the health of her children and on childrearing.

Though our patient had depression, it reached significant severity only for a period of three months. Hence, the depression could not completely account for the anorexia. The anorectic symptoms were also found to be out of proportion to the severity of depression. Our case is similar to the only other case reported in literature of anorexia following a termination of pregnancy (Thomas and Brian, 1982).

In the Indian context, typical anorexia is reportedly less prevalent and the presentation is usually atypical (Khandelwal and Saxena, 1990). Cultural factors may also have played a role in our case. In Indian culture there is little emphasis on slimness and dieting, moreover, food and eating are symbols of nurturance and family life. Not eating is hence viewed as a rejection of these

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values and has been found to occur in the context of family conflicts (Chandra et al., 1995). The presence of marital conflict in our case and improvement with marital therapy indicates that family factors may have played a major role. In addition, our patient also had several concerns about child bearing and had undergone multiple termination of pregnancies. Anorexia in this context also reflected conflicts about reproductive functioning and regarding repeated obstetric and gynecological procedures.

This case illustrates the importance of an eating disorder occurring in women in relation to reproductive events. Anorexia occurring at a later age, specially in cultures where typical Anorexia Nervosa is unusual should alert us to other possible etiological factors apart from a need to be thin.

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