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INTEGRATIVE APPROACH TO MANAGEMENT OF ANOREXIA NERVOSA : A CASE REPORT

A. AVASTHI, PUNEET, M.K. DAS & S. GUPTA

ABSTRACT

In-patient management with initial focus on weight restoration for an emaciated young girl with anorexia nervosa is reported. Integrative approach to management of this case yielded gratifying results which are maintained beyond one year after-discharge period.

Key words : Anorexia nervosa, management.

Anorexia nervosa is common in the West, however.case reports from India are few (Khandelwal et al., 1995). A serious and often chronic condition, it requires ongoing commitment and attention to the multiple interdigitating diagnoses and comprehensive treatment plan (Practice Guidelines APA, 1993). We present the management of a case of anorexia nervosa where an intergrative approach was followed. It was particularly challenging because of little prior experience with the presentation of this disorder in our cultural milieu and its management in our clinical setting, often a ripe situation for the adoption of eclectic (do-what-works) approach.

THE CASE

Our patient, a 17 year single female of lower socio-economic status of hindu nuclear family, hailed from an urban settlement 60 km from our centre. In 1989, as a 13 year old class 8th student, she decreased her food intake, beca.:se she percieved herself to be too fat (though not appearing to be so). Despite the loss of weight, she continued to restrict her food intake which became half of her usual by 1992, when her menstruation ceased to occur.

In 1993, in an attempt to further lose weight, she began to take long walks. The diet reduction continued and by May 1994 her intake consisted of only plain lime water. She developed patches of discoloration on the skin of her hands and feet. There was no associated sadness or depressive ideations. Parental concern prompted her admision to the local government hospitals, where she was given I/V fluids and certain medications over a few days and then referred to our centre in the last week of July,1994.

Examination at admission revealed an emaciated patient with a quetelet index of 7.7 (weight=22 kg and height 169 cm) pallor and lymphadenopathy (supraclavicular and axillary). She was too weak to turn on the bed by her herself.No sadness was observed or reported. The patient considered herself fat even at that point of time, and ascribed her admission in the hospital to skin lesions on her hands and feet. She was diagnosed as a case of Anorexia Nervosa as per the criteria of ICD-10 (WHO, 1992).

MANAGEMENT

The initial focus was at improvement of her physical status and prevention of medical complications. Psychological interventions other than establishment of therapeutic alliance were postponed. Investigations revealed hemoglobin of 6.2 gm% and proteins 5.8 gm/dl. Estradiol was at prepubertal level of 115pmol/1. A.M. Cortisol was 480 nmol (normal: 400-690). T_3 was undetectable and T_4 was 118 nmol/l (normal: 0.8-1.8 and 60-120 respectively).

The consulting physician and dietician formulated a special enteral diet consisting of milk, wheat and sugar providing 1158 k cal/litre. This was not tolerated on increasing the quantity and was substituted with a curd based diet, which was also given

through nasogastric tube, as the patient refused oral intake. The skin patches were diagnosed as pellagra for which vitamin supplements were given. A multiphasic physiotheraphy regimen which progressed from passive exercise, vertical orientation on the tilt table; active exercises when sitting or supine; and then assisted walking; was initiated to facilitate mobilisation of the patient.

A month after admission, by which time her physical condition had stablised, behaviour therapy with positive reinforcement in the form of small gifts targeted at weight gain through oral intake of food was instituted. Over the next 30 days, her weight increased by 5 kgs. The patient started taking some snacks and could walk with support. Weight, laboratory parameters and anthropometric measurements were monitored at regular intervals for the patient's feedback.

In September 1995, with further improvement in physical status, she was noticed to be irritable, crying often and having disturbed sleep. Imipramine was started and gradually increased to 100 mg/day. Family assessment revealed conflictual relationship between the patient and her mother. However, family therapy could not be initiated as the family expressed inability of the mother to come to our centre on account of practical difficulties.

By the middle of October she had resumed taking 3 meals a day and weighed 33 kg. Supportive psychotherapy with ventilation, counselling and guidance was started as by then a good rapport had been established with the patient. She was discharged two weeks later, after 3 months of ward stay. The patient has kept regular follow up with our centre. Her weight which is regularly monitored is maintained at 45 kg. Her menstruation resumed after 6 months of discharge but a regular rhythm is not established as yet. Supportive psychotherapy is being continued.

DISCUSSION

Treatment of anorexia nervosa is considered controversial and speculative (Larocca, 1984), primarily because the etiology of the disorder is unknown and the needs of the patient are not uniform (Hsu, 1986). In-patient treatment, essential in our extremely emaciated patient, is considered mandatory in patients who have lost greater than 20% weight or if the patient continues to lose weight despite medical and psychological interventions (Larocca, 1984).

Coercive treatments, like tube feeding are not routinely advised (Practice Guidelines, APA, 1993); but the severely malnourished state of our patient warranted its use. Behaviour modification techniques directed at weight gain have probably been more effective than those that focus on eating behaviour per se, and positive reinforcement contingent on weight gain are almost always used (Hsu, 1986).

Depression is a common concomitant psychiatric diagnosis (Eckert et al., 1982). Our patient too presented with depressive symptoms, but the genesis of such depression manifesting in the course of management is hard to speculate. Nevertheless, once treated with antidepressants, not only such symptoms improved, but her deitary intake also increased substantially. Thus, antidepressants may have a primary role in the treatment of anorexia nervosa, a view advanced by Morgan et al. (1983).

Thus, from our experience with the management of this case, we would advocate in-patient treatment with the initial aim of preventing medical complications and weight restoration for a severely emaciated patient; a continuous effort to engage the patient as a collaborator in the treatment and subsequent employment of psychotherapeutic techniques like behaviour therapy, family therapy or individual psychotherapy or even pharmacotherapy, and to keep the patient on regular follow up after discharge from the hospital. However, the management would need to be tailored to the demands of each case as it presents, with an effort to integrate sequentially in a planned manner various therapeutic modalities advocated for the management of anorexia nervosa.

REFERENCES

Eckert, E.D.; Goldberg, S.C.; Halmi, K.A. et al. (1982). Depression in Anorexia nervosa. *Psychological Medicine*, 12, 115-122.

Hsu, L.K.G. (1986). The treatment of Anorexia nervosa. *American Journal of Psychiatry*, 143, 573-581.

Khandelwal, S.K.; Sharan, P. & Saxena, S. (1995). Eating disorders : An Indian Perspective. *In-*

ternational Journal of Social Psychiatry, 41 (2), 132-146.

Larocca, E.F. (1984). Symposium on Eating Disorders. *Psychiatric Clinics of North America,* Vol. 7, No. 2, 287-298.

Morgan, H.G.; Purgold, J. & Walbourne, J. (1983). Management and outcome in Anorexia nervosa : A Standardised prognosis study. *British Journal of Psychiatry,* 143, 282-287.

Practice Guidelines for Eating Disorders (1993). APA Practice Guidelines. Washington DC : American Psychiatric Association.

World Health Organisation (1992). The ICD-10 classification of mental and behavioural disorder : Clinical descriptions and diagnostic guidelines. Geneva: WHO.

AJIT AVASTHI, MD, Associate Professor; PUNEET, MBBS, Junior Resident; M.K. DAS, MD, Senior Resident; S. GUPTA, MBBS, Junior Resident; Department of Psychiatry, Postgraduate Institute of Medical Education and Research, Chandigarh 160012.*

** **Correspondence***