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Anorexia Nervosa: Challenging Clinical Case Study

Meera Saravanan.1,Maheswari.T.2, Riya Jacob.3, Jayasudha.A.4

1-Professor cum Head of the Department, 2- Associate Professor,
3-MSc Nursing II year, Mental Health Nursing, 4- Principal,
PSG College of Nursing, Coimbatore, Tamil Nadu, India.

ABSTRACT

Anorexia nervosa involves emotional challenges, an unrealistic body image, and an exaggerated fear of gaining weight. Case study approach was used. A teenager girl admitted to the psychiatric ward with complaints of refusal to take food and fluids for two years. The client exhibited crying, self harming behaviours and suicidal intentions. She had an experience of attending one of their relative's family function of menarche. Their relatives were commenting that this girl would be the next one to attain menarche. She perceived a disturbed body image afterthen. She was anxious with irritable mood. Her body mass index was 9.50 kg/m2. She weighed only 20 kg. Administered antipsychotic drug. Nutritional counseling supported refeeding. Positive Cognitive Behaviour Therapy helped to build client's strengths by shifting the attention and meaning and developing more adaptive schemas. Her weight increased by 3.61 kg towards discharge. She started practicing adoptive coping mechanisms.

Keywords: anorexia nervosa, coping, positive cognitive behaviour therapy, brief strategic therapy

1. INTRODUCTION

Anorexia is an extremely unhealthy and sometimes life-threatening way to cope with emotional problems. Anorexia nervosa is an eating disorder causing people to obsess about weight and what they eat. Anorexia nervosa often involves emotional challenges, an unrealistic body image, and an exaggerated fear of gaining weight.(1) However, it can affect people differently. Anorexia nervosa is a syndrome characterized by three essential criteria:

- a self-induced starvation to a significant degree
- a relentless drive for thinness or a morbid fear of fatness
- the presence of medical signs and symptoms resulting from starvation.

National Institute of Mental Health and Neurosciences describe anorexia nervosa as the mental health condition most likely to be fatal.

1.1Epidemiology

Anorexia nervosa often appears during a person's teenage years or early adulthood, but it can sometimes begin in the preteen years or later in life. Among women life time prevalence is approximately 0.5 to 1% in the United States. People often think of anorexia nervosa in connection with females, but it can affect people of any sex or gender. For every 10 females diagnosed, only1 male is diagnosed. (2)

The World Health Organization estimates that worldwide 70 million people have an eating disorder. Lifetime prevalence statistics suggest that about 0.4% of women and 0.04% of men will meet criteria for anorexia during their lifetimes. (3)

2. METHODS

Case study approach was used.

A thirteen years old eighth standard studying female entered the psychiatric outpatient department with the chief complaints of refusal to take food and fluids for two years. She looked dull and malnourished. She had very poor body built.

Her mother was the informant. She informed that her daughter reduced the food intake to two idili and then to half idili and stopped drinking water. The client exhibited crying, self harming behaviours like hitting herself and suicidal intentions since one month of her admission. Sleeping pattern, bowel and bladder pattern was normal.

The client was brought up by her parents. Mile stones were normal with no significant neurotic traits. Her relationship with peers was good. Her interpersonal relationship was disturbed when asked to have food. She outbursts with anger and hurts herself purposefully on seeing the food.

Her mother reported on the precipitating factors that her daughter had an experience of attending one of their relative's family function of menarche. Their relatives were commenting this girl that she would be the next one where as she had her elder sister not attained menarche. This brought her a perception of disturbed body image. Hence forth she gradually stopped the normal intake of food. She had nearly eight kilogram of weight loss in a month. She was admitted to the psychiatric ward.

The proven biopsychosocial factors for anorexia nervosa are:

- Genetic: Family inheritance, family history of psychiatric disorders and substance use disorders.
- Neurochemical : Nor-epinephrine imbalances in the brain, Endogenous opiate imbalances
- Psychodynamic : Fear independence and maturation, lack of sense of autonomy and need for control in life, history of bullying about body shape, low self-esteem, anxiety, obsessive personality, history of dieting. stressful life events like puberty
- Social : Social media , pressure to fit in with cultural norms, peer pressure. (4)

On few psychiatric interviews with her, she was found co-operative, attentive and interactive with instability of mood. She experienced emotions like fear, irritability and guilt. There was no disturbances in thought and perception. She was well oriented, memory was intact and total insight was present. She maintained good eye to eye contact during interviews.

During the initial general physical examination, her weight was 20 kilogram, eyes sunken and neck with thin muscle and no thyroid enlargement. She was feeling cold. Dull heart sound was heard. Calculated her body mass index and found to be 9.50 kg/m2. Complete hemogram was done, result showed

Table.1:Results of haemogram values

BLOOD INVESTIGATIONS	PATIENT VALUE
Total WBC Counts	1.1 X 10^3 / uL
Absolute Neutrophil	0.7 X 10^3 / uL
Lymphocyte	0.3 X 10^3 / uL
Monocyte	0.1 X 10^3 / uL
Eosinophil	0.0 X 10^3 / uL
Basophil	0.0 X 10^3 / uL
Triglycerides	73 mg/dl
LDL Cholesterol	145 mg/dl

The client clinically presented with feeling cold with low body temperature and blood Pressure. She exhibited compulsive behavior of not taking food and fluids when emphasized to take. She maintained social isolation at times. She was anxious of puberty changes and menarche.

2.1 Criteria for hospitalization:

- Vital signs unstable
- Cardiac dysrhythmia
- Severe dehydration
- Refeeding syndrome of moderate to severe nature
- Bodymass index <16 kg/m2
- Acute medical complication as a result of malnutrition.
- Laboratory testes - complete blood count, electrolyte, protein, LFT, RFT,TFT and Urinalysis

X-RAY (Broken boke pneumonia), Electrocardiogram (Heart Irregularities) and Bone density testing. (5)

The client was admitted with low body mass index, malnourished, low self esteem and suicidal thoughts.

2.2 Treatment Programme: Early diagnosis and treatment are essential.

Goals for treatment:

Administration of behaviors to normalize eating and weight gain

Change distorted beliefs and thoughts on restrictive eating

2.2.1 Positive Cognitive Behaviour Therapy (CBT)

Mental health is more than the absence of mental disease. Positive CBT focus on building client´s strengths and on what works instead of just reducing problems.

Padesky considered resilience as development, not a trait and explain it as the capability to cope with and adapt in the face of difficulty and/or to rebound back and reestablish positive functioning when stressors become overwhelming. The model of resilience stems from the observation that many children can achieve a positive developmental outcome despite adverse experiences. Resilience assistances clients to cope with negative life events. Resilient persons continue in the face of difficulties and when needed, accept conditions that cannot be improved.

Building the client's strengths

Shifting the attention and meaning

The emphasis is placed on how clients think and what they pay attention to as an approach to modification their condition to be the better.

First strategy: is to recognize feelings and the past without allowing them to regulate what clients can do. They are asked to generate more kind and supportive stories and discover a gentler, calmer, and more positive vision of themselves, others, and/or the condition

Second strategy: is to ask clients to modification what they are paying attention to in offending circumstances. Guiding attention to the clients' successes instead of their fiascos produces an encouraging expectancy. Clients begin to see themselves or the situation in a more positive light.

Third strategy: is to focus on what clients want to be different in the future. This accentuates the opportunity of change and centers clients on the future opportunities rather than on the problems.

Fourth strategy: is to challenge maladaptive beliefs about themselves, others and the world. Therapist assists the clients to find supportive thoughts and schemas that contribute to a more positive understanding of the self, others, and the world.

Developing More Adaptive Schemas

Role playing

Role-playing is an exercise where the client plays a role of himself to be a child in an early life scene that evoked the negative feelings connected to the schema of current therapy focus and replaying the event to more positive experience. This offers a potent first experience of what it would be like for the client to hold an alternative schema and also to respond to events and others in new ways on an everyday basis.

2.2.2 Strengths Based Cognitive Behaviour Therapy

Padesky and Moony developed Strengths-Based CBT, a four-step approach to building positive qualities.

Step 1: Search for strengths

Step 2: Construct personal model of resilience

Step 3: Apply the personal model of resilience to areas of life problems

Step 4: Practice resilience.

Once clients have practice in using their personal model of resilience in intentional experiments, therapy shifts to look for reasonable chances to practice resilience in daily situations. The clients are fortified to welcome negative life events as opportunities to train resilience. Some clients comment that this view changes life into a **'win–win'** experience. If things go well, they win. If the things do not go well, they have extra chance to 'win' by being resilient. This viewpoint often allows clients to embrace challenges and can help them to stop avoidance. Thus, the practice of resilience not only helps people to cope with life difficulties, but it also reduces the amount of life events that are experienced as aversive. (6)

2.2.3 Brief Strategic Therapy

Brief Strategic Therapy approach conceptualizes problems as the product of a complex process of recursive interactions between individuals and their reality, in which individuals' repeated ineffective attempts to solve the problem inadvertently maintain or exacerbate it. People have a natural inclination to repeat solutions that have proven to be functional in the past. Generalizing such solutions to different situations, or reapplying the same strategies when they no longer produce the desired effects, creates and maintains a maladaptive way of thinking about and reacting to the problem known as a dysfunctional perceptive-reactive system.

Therapeutic communication consists of strategic dialog and analogical language such as metaphors, anecdotes, aphorisms, stories to reframe attempted solutions as threatening and dangerous with fearing restricting, thus subverting the perception of the problem. (7)

Three phases of treatment include:

Phase I: Therapeutic Alliance phase

Miracle Fantasy Technique - to induce a form of positive self-deception through statements like "What should happen in your life to say, "My problem has been resolved?"

How worst technique - to recognize high risk factors through conversations like

"How will you voluntarily make your situation worst? "

"Why do you wish to proceed your life this manner?"

Conspiracy of Silence - to interrupt current eating system by family members through the follow up of "avoid talking about or acting on the problem"

Phase II - Paradoxical Diet phase - leads to complete blocking of anorexic symptoms in few sessions. Individual is asked to think of what they would like to eat the most and carefully prepare and eat as much of those things as they want during mealtimes. Encourages,

" Every time you eat something for your three daily meals, can have even more than three times".

" You have to eat nutritious meals at least three times a day"

Phase III - Small Transgressions phase-to maintain eating goals. Stimulate thinking by,

"Treat yourself to adequate portion of food each day".

Phase IV - Positive changes or Self confident phase. Talk as

"You are responsible over your achievements. "

"Be consistent in your eating behavior."

"You made up your weight gain to 24 kilograms.

3. Nursing implications

Establish a therapeutic relationship with both the patient and her family

Restore the weight to a level between the ideal body weight and the patients ideal weight

The provision of a balanced diet aimed at gaining 0.5-1 kg weight per week

The insertion of NG tube and feeding.

Nursing Measures taken for this client include:

- Provision of small and frequent meals under supervision
- Monitoring vital signs, capillary refill, status of mucus membrane and skin turgor.
- Monitoring intake and output chart
- Maintaining electrolyte balances and renal functions
- Administering supplements
- Allowing to eat with family members

Art Therapy was administered as the client was doing good at pencil sketching, drawing and painting at the Occupational therapy unit.. Administered antipsychotic drug T.Olanzepine 5 mg HS. Suicide prevention measures taken up by close monitoring for suicidal thoughts and plans, providing safer environment and family responsibilities for the client.

Nutritional counseling supported the client so much for refeeding. She was able to take three meals per day during the last week of her hospitalization. Family counseling was done by suggesting for supervised eating pattern and fluid intake, anger management and compliance towards treatment.

4. Prognosis

Good prognosis was found in the client as she improved with better self-confidence and positive behavioral changes. Mortality is higher if co-occurring psychiatric illnesses are present such as substance abuse. Patients can die as a result of suicide or other medical complications.[5]

5. RESULTS

It took more than a week time to win the trust and co-operation of the client for brief strategic therapy. The client gained 3.61 kilogram of weight by four weeks of hospitalization. There was no suicidal thoughts during discharge. She was stable with vital parameters such as body temperature, pulse and blood pressure. She maintained adequate fluid volume with no signs of dehydration.

The emotional and psychological challenges of anorexia nervosa can be hard for a person to overcome. It can be challenging for a person with anorexia nervosa to engage in treatment. As a result, the person's participation in therapy may fluctuate. Relapses can occur, especially during the first two years of treatment. (4)

6. **DISCUSSION**

Maria Rago from the National Association of Anorexia Nervosa Disorders suggested for anorexia nervosa to be kind and respectful rather than judgmental and look into providers of treatment to find good progress.(4) Cognitive Behavioral Therapy also helps the person find new ways of thinking, behaving and managing stress.

British Medical Council Psychiatry reported that anorexia nervosa patients tend to choose the same types of foods at each meal and these eating behaviors persist during short-term recovery. High dietary energy density scores are more predictive of better outcomes than total caloric intake. A follow-up study of food intake one year after hospital discharge showed that individuals with anorexia nervosa tend to revert to pathological eating and to the low calorie intake. Individuals with anorexia nervosa tend to find it difficult to eat more than 10 to 20 kcal/kg per day (30 kg = 300 to 600 kcal/day)

Both American Psychological Association and National Institute for health Care Excellence guidelines specify clearly the first goal of treatment is weight restoration. These guidelines report the weekly weight gain that can be expected both in AN inpatients and outpatients which includes refeeding in severe and resistant cases, clinical improvement requiring caloric intake effects of micronutrients deficiencies and alterations on adolescent patients, inpatient treatments and risks during refeeding. Dietary choice is driven by preference of vegetarian-based, low energy-dense diet of food type, rather than a complete starvation mode. (8)

The client was made to stick onto a good and a regular eating pattern and relax herself. Follow up and review meetings were planned with the family.

7. CONCLUSION

The client was taught adaptive coping mechanism to face menarche. Anorexia nervosa is a serious mental health condition and a potentially life threatening eating disorder. However, recovery is possible with the right treatment.

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