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Case Report

Case Report of Anorexia Nervosa

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Abstract

Anorexia nervosa (AN) is one of the most severe psychiatric disorders and is often associated with a poor outcome along with significant morbidity and mortality rates. The main features include a relentless pursuit of thinness, body image disturbances, and severe food-restriction leading to extreme weight loss. Anorexia Nervosa is a Western Psychiatric disorder and not seen much in Arab culture and especially in Gaza Strip In this article, I presented a case who diagnosed with Anorexia Nervosa by the Endocrinologist and was referred for psychiatric evaluation and treatment. At the end I discussed the challenging in making the diagnosis, and the treatment plan.

Keywords: *Anorexia Nervosa (AN); Morbidity; Mortality*

Introduction

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released in May 2013 [1]. It includes a significantly revised eating disorder section [2]. The fourth edition [3], DSM-IV, specified only two eating disorders, anorexia nervosa (AN) and bulimia nervosa (BN). In DSM-5, the eating disorder section is renamed 'Feeding and Eating Disorders' and specifies three eating disorders: AN, BN, and binge eating disorder (BED); and three feeding disorders: pica, rumination disorder (RD), and avoidant/restrictive food intake disorder (ARFID). The DSM-IV listed some of the feeding disorders in the 'Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence' chapter. Anorexia nervosa (AN) is a potentially fatal eating disorder that predominantly develops in adolescents [1]. Anorexia nervosa (AN) is one of the most severe psychiatric disorders and is often associated with a poor outcome along with significant morbidity and mortality rates [4]. The main features include a relentless pursuit of thinness, body image disturbances, and severe food-restriction leading to extreme weight loss. Eating disorders (ED) predominantly occur in adolescent and young adult women [5] with a prevalence of over 3% in 12- to 23-year-olds [6]. The current case study aimed to present a rare case of Anorexia Nervosa in Palestinian society in the Gaza Strip.

Case Report

Demographic information

Name: S

Age: 15

Gender: Female

Education: Primary

Marital Status: Single

Occupation: Student

No. of siblings: 4

Birth Order: First born

Referral Source: The client was referred by endocrinologist to get psychological treatment.

Presenting Complaints

According to the Mother: My daughter was seeing Endocrinologist for the last few months due problem of growth problem and she did many blood tests and urine tests. Three months ago, she started to withdraw from the family and sit alone in her room, she had outburst of anger against me and her brothers, she started to decrease amount of food she is eating and only when she is with us in the table, she only drink milk and leave the table saying she had no appetite. Her mood is very depression and anxious and accepting our advice to eat. She said that she wants to lose weight because she had the idea that she is fat and had more weight. Mother said that her weight in February was 48 KG and after three months, it is 36 Kg. Now she is not eating anything, only she drinks cub of juice and refuse eating anything and when we ask her to eat she starts shouting on us and leaves the room and close her room door. We visited the endocrinologist today and he saw her shape he said that she need to get psychological assessment and treatment for her condition. He gave them referral to general hospital for admission and getting IV fluid because her Acetone level in very high.

According to the client: She said she stop eating because she thought she will gain weight, she said she hat people and her parents due to continue fighting at home. She said she like to be alone in her room and not sharing her family their activities and food. She said that she expected bad thing will happen to her and she is weeping most of the time, feeling sad and the life is worthless and no one can help her.

Interview Information

The girl was sad, weeping, no eye contact and had negative thoughts of her body that she is fatty and want to lose more weight. She is emaciated and had tears in her eyes during the interview. She had obsessional thoughts that she is fatty and want to lose her weight. No hallucination or other thought disorders. Mood is very depressed, no suicidal ideas.

Family History: Father is assistant pharmacist and mother is pharmacist and setting at home. There are many family problems between parents due to education of each of them. Father is very abusive for mother in front of the girl and other children. She had for siblings, twins (Boy and Girl) age 12 years and another twin (Boy and Girl) age 9 years.

Personal History: A girl 15 years old, with history of hormonal disturbance and not getting her premenstrual cycle was treated by Endocrinologist with TSH = 15.9 (normal 0.5 - 5 url/ml) and she had depression symptoms at age of 13 years with crying spells, withdrawn form family, loss of appetite, and outburst of anger toward family members. Such symptoms were observed for 4 months and without treatment disappeared. She had no other mental or medical condition except the growth problem and delay of the menstruation which was increased the last three months after stopping eating.

Premorbid Personality

Premorbid functions and premorbid personality characteristics that may have implications for how the individual coped with his mental health disorder were evaluated. It was noted that client had avoidance coping, low self-esteem, and low self-confidence.

Tentative diagnosis

Anorexia Nervosa- Restricting type: 307.01 (F50.1).

Anorexia Nervosa

Diagnostic Criteria

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding note: The ICD-9-CM code for anorexia nervosa is 307.1, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below).

Specify whether

(F50.01) Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

(F50.02) Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if

In partial remission: After full criteria for anorexia nervosa were previously met. Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI > 17 kg/m^2

Moderate: BM116 - 16.99 kg/m^2

Severe: BM115 - 15.99 kg/m^2

Extreme: BMI < 15 kg/m^2

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition. Washington DC.

Prognosis

Anorexia Nervosa often had an emotional element beside identity disorder for may last for few years. It can significantly interfere with the lives of individuals who have it and usually requires treatment for it to resolve. Therefore, people with anorexia nervosa are usually thought to need treatment for at least a year to prevent its recurrence. The prognosis for Anorexia Nervosa in this case was encouraging and favorable and there are good chances of recovery. The prognosis is good because the girl started to cooperate to take the antidepressant and to eat daily and weighing herself every day.

Treatment Plan

Lifestyle changes

The client was advised to make certain changes which would be helpful in overcoming her symptoms:

- Eating in small amount in regular base: The girl was advised to eat small amounts of food regularly which will help to gain weight.
- Avoid confrontation with parents during meal time
- Get enough balanced food and avoid food staff with additives. The girl was asked to health food in small amount.
- Eating healthy and balanced diet: She was advised to use vegetables, fresh fruits, whole grains and fish to keep herself healthy

Progressive muscle relaxation techniques: The girl was taught relaxation techniques to reduce the level of anxiety before big meals. When practiced regularly, progressive muscle relaxation can reduce anxiety related to food and weight increasing and increase feelings of relaxation and emotional well-being.

Cognitive Behavioral Therapy: Cognitive Behavioral Therapy is evidence-based therapy for anorexia nervosa disorder. Cognitive behavioral therapy addresses negative patterns and distortions and the way we look at the world and ourselves. The girl was advised to examine how negative thoughts, or cognitions were contributing to here problem and with a rational thought patter, he can reduce his obsessional thoughts about the weight. She was explained how our negative thoughts; not external events affect the way we feel. In other words, it's not the situation you're in that determines how you would feel, but your perception of the situation.

Behavior therapy was also planned as a treatment intervention by focusing on encouraging activities that are rewarding, pleasant and gave her sense of satisfaction and helped to reverse the patterns of avoidance and worry that were making her eating pattern worse.

Discussion

In this article, I presented 15-year-old female student. She had few friends and she not used to play with the peers. The girl was presented by her mother as advised by her Endocrinologists with symptoms of persistent refusing food, weight loss, stop of menstruation, fatigue, muscle, anger spells and cursing mother and other family problem. Keeping in view, the presenting complaints and results of psychological assessment the client was diagnosed with Anorexia Nervosa Disorder. As an intervention to treat her problem, psychoeducation, relaxation techniques, life style changes, Cognitive Behavioral Therapy (CBT), and Antidepressant (Escitalopram 10 mg bd) was the mainstay of the treatment.

Since the 1960s, eating disorders such as anorexia nervosa began to be recognized as an important health problem among adolescent girls and young women in Western societies, and their prevalence has increased over time [7]. Although the survey methods and ages of the subjects in other studies differed from those in our study, the prevalence of anorexia nervosa was shown to be 0.3% of young females in the Netherlands [8], 0.5% of teenaged girls in Germany [9]. 0.3% of secondary school students in Hungary [10], and 0.2 - 0.3% of girls aged 13 to 18 years in the United States [11].

In Western countries, the prevalence of anorexia nervosa among young females was reported to be 0.3% and bulimia nervosa was 1% [12]. In Japan, the rate of anorexia nervosa was reported to be lower at 0.2% but higher for bulimia nervosa, 2.9% [9]. Studies conducted in the non-clinical setting indicated that eating disorder symptoms were prevalent among Japanese female adolescents, ranging from 5 to 10% [13]. Many young females prefer to be thinner due to an extreme desire for thinness and dieting behaviors regardless of their actual weight. They even emphasized certain part of their body such as circumference of hips, stomach or thighs as their target body image rather than just depending on overall weight [14]. Few studies were conducted in the middle east to investigate the prevalence rate of eating disorders among adolescents, in study of two hundred and three Egyptian adolescent females were enrolled in this cross-sectional study.

Their mean age was (17.4 ± 0.64) years old. The results showed that sixty-eight percent of the students were within normal weight, 3.3% were underweight, while 18.2% and 10.5% were overweight and obese respectively [15]. Researchers suggested that excessive exposure to Western mass media depicting the thin ideal body is the main factor that causes body image disturbance among women and plays the main role in developing eating disorders [16]. As compared to its prevalence in the Western countries, the prevalence of EDs in non Western countries was lower but seemed to be increasing [17]. More, in a systematic analysis of data collected from 25 different countries declared that symptoms of EDs were more pronounced in non Western countries than that in Western countries in contrast to expectations [18]. Few studies of eating disorders were conducted in Middle East countries. In Egypt, Fawzi., *et al.* [19] detected that 11.2% of secondary schoolgirls in Sharkia Governorate had a score above an EAT 40 score of 30, indicating the diagnosis of eating disorders.

They attributed this to the high level of concern about body shape that is reinforced by ideas about perfectionism that considered thin ideal body as a standard of feminine beauty. Similarly in study 400 participants attending four weight management centers in Tanta, Gharbia Governorate, Egypt during the period from July to December 2016, the study revealed that more than half (65.0%) of the patients attending the weight management centers in Tanta were complaining of Eating Disorders (EDs), which was higher than what was reported by other studies. This could be attributed to the fact that this current study was carried out on the weight management centers, which are more at risk of EDs [20]. In Jordon, a study has investigated the occurrence of body image dissatisfaction among adolescent schoolgirls in Amman, Jordan, and the risk factors that are known to predispose it including individual, familial and social variables. A sample of 326 adolescent girls aged 10–16 years was recruited from public and private schools in Amman. Approximately, 21.2% of participants displayed body image dissatisfaction in which physical changes associated with puberty and exhibiting negative eating attitudes were associated with this dissatisfaction. Additionally, mass media messages, as well as peers and family pressures towards thinness were associated with participants' preoccupation with their body image [21].

Conclusion

Anorexia Nervosa is uncommon in our society. Early detection and treatment of the psychiatric manifestation with antidepressant, forced feeing, cognitive behaviour therapy, as well as psychotherapy is lifesaving of such cases. Keen monitoring of the patient food and weight and impact of antidepressant and the course of the illness is also of outmost importance to detect any new symptoms and therefore, to take appropriate measures.

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Conflict of Interest

None declared.

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