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CASE PRESENTATION

ANOREXIA NERVOSA AND THE ADOLESCENCE -CASE PRESENTATION-

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ABSTRACT

In this article we present the case of a patient admitted in our clinic for a self-imposed food restriction, marked weight loss, obsessive ideas and every day exhausting exercises. Obtained data from his personal history, clinical examination and psychological evaluation were significant for DSM IV-TR and ICD 10 diagnostic criteria for Anorexia nervosa restrictive type.

Keywords: anorexia nervosa, adolescent, physical activity, weight loss

INTRODUCTION

Adolescence is one of the periods with the highest risk for the appearance of eating disorders (anorexia nervosa and bulimia).

Although eating disorders such as anorexia and bulimia are usually considered a disorder that mostly affects teenage girls, however there are quite many boys diagnosed with eating disorders.

Anorexia nervosa is an eating disorder characterized by immoderate food restriction, inappropriate eating habits or rituals, obsession with having a thin figure, and an irrational fear of weight gain, as well as a distorted body self-perception. It typically involves excessive weight loss and is diagnosed approximately nine times more often in females than in males [1]. Due to their fear of gaining weight, individuals with this disorder restrict the amount of food they consume. Anorexia nervosa is often coupled with a distorted self image [2,3] which may be maintained by various cognitive biases [4] that alter how the affected individual evaluates and thinks about their body, food, and eating [5]. People with anorexia nervosa often view themselves as overweight or "big" even when they are already underweight [6].

CASE PRESENTATION

Reasons for hospitalizations

B.I.A. is a 15 years old patient that was brought by his parents for: a self-imposed food restriction (<1000 kcal/day). He followed a diet composed of fruits, vegetables and meat only boiled or grilled; marked weight loss (21 pounds in about 12 months); obsessive ideas: “I do not want to get fat again like I was before”; every day exhausting exercises (playing football, "long daily walks, went throughout the city on foot every day").

From family history we keep in mind that his father, aged 40 years old, is a perfectionist and he presented panic attacks in his youth.

Personal physiological history: first child coming from a pregnancy affirmative normal until birth, weight at birth = 4000g, APGAR=10, good postnatal adaptation.

The psychomotor development was normal during age stages.
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**Personal pathological history:** insignificant.

**Living and working conditions:** the patient is a student in ninth grade with good academic results, especially in the last period ("wants to take only 10 to school"). She lives with her parents being their only child and he has his own room. He denies alcohol, cigarettes or drugs consumption.

**Medical history:** One year ago the patient has self-imposed a „healthy“ diet consisting in yoghurt, salads, cooked meals with total exclusion of sweets, soda and bread. The patient told us: „At home I am non-stop stressed with food, they want to make me so“ (he makes the symbolic gesture for fat people).

He associates exhausting physical exercises: forced march through town, football. Affirm: „I love football, I go to football every day and I want to play increasingly better.“

His father told us: „My boy, get started and make some exercises because you have tummy! Since then he began to stop eating.”

From physical examination we retain: waist of 177 cm and a weight of 47 pounds (his mother told us that in January 2013 he had 68 pounds, 60 pounds in August 2013 and at the admission in November he had 47 pounds). His body mass index was 15, which shows us a severe degree of underweight.

Other alterations are: sunken eyes, pale skin and cold extremities. Adipose tissue poorly represented. Mild kyphosis. Excavated abdomen.

The rest of the physical examination was in normal limits.

**Psychic examination**

On admission the patient came accompanied by his parents. The general aspect was of a careful adolescent, in street outfit, proper hygiene.

Glance vivacious. Mimics and gestures were mobile, in accordance with his mood. Eye contact easily achieved and maintained. Conscious and cooperative. Temporo-spatially oriented auto and allopisic.

The insight is present: „I was fat, now I’m skinny, but I’d like to take a little bin in weight“. Perception: without quantitative / qualitative perception disturbances at the time of examination.

**Attention:** spontaneous and voluntary normoprosexia.

**Memory:** fixing and evocative normomnezia.

**Thinking:** Present spontaneous speech, coherent, focused on his lifestyle and diet.

Obsessive ideas: „I do not want to get fat again, like I was before“. He also says: „I do not eat fried foods, bread or carbonated drinks that are very unhealthy“.

Perfectionism: mom says: „He is a perfectionist, he wants to do everything right. He wants to take only 10 at school“.

Also she told us: „He is a very tidy boy, he wash his sneakers every day to be like new again. His bed must be done right, clean and very ordered.”

The patient said: „I’m a perfectionist, I want everything to be okay. A jar should stay in the closet not on the table; if I see that it isn’t at his place, I put it in the closet and I’m very nervous.”

**Eating behavior:** a self-imposed food restriction.

Mom says: „He eats chaotically and after his own rules, rules that you cannot change“. The patient said: “I’ve decided to quit (forever) juices, fast food, fried, pastry, bagel, cakes, pies, strudels, etc. I’ve also decided to eat more vegetables, fruits, meat only boiled or grilled. Regarding dessert / sweet I take it from honey, nuts, yoghurt and occasionally mints “.

Afectivity: „He is always concerned by his diet, nothing enjoys him anymore“. From what he wrote about him we retain: "My life story is like an apple. When is fresh is good, when it crashes it becomes a total and silly annoyance, but I’ve learned to live, drink and eat healthy in any situation".

Irritable when he talks with the mother about his diet: „but what would you like me to eat?...Chips?“. Most of the time when we discussed about his diet became irritable and he had many contradictory talks with his mother.

**Nictemeral rhythm:** without changes.

During hospitalization the paraclinic explorations have continued, as follows:

EEG - trail background without pathological elements.

Beck depression inventory scale:1 (normal limits without clinical significance).

Lab tests showed no significant changes.
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Positive diagnosis
Axis I: Anorexia nervosa restrictive type
Axis II: In observation obsessive personality disorder
Axis III: -
Axis IV: -
Axis V: GAF=90 (no significant difficulties in social or professional training)

Differential diagnosis
Somatic disorders in which may appear marked decreases in weight (AIDS, gastrointestinal disorders, malignancies) - patients receive proper nutrition and have no desire to lose weight with severe food restriction.

Major Depressive disorder - the patient loses weight due to decreased appetite, but he isn't concerned about diet.

Schizophrenia - strange behavior related to diet, possibly with weight loss, without being concerned about the fear of gaining weight.

Somatisations disorder – it can appear symptoms like weight loss, vomiting, but patients are not preoccupied about the fear of weight gain.

Dysmorphic body disorder - the patient is not only concerned about weight and body conformation but also of its imaginary defects.

Treatment
During the hospitalization we developed a rigorous meal plan with the patient, trying to reach an intake of 1500-2000 kcal / day.

We negotiated the weight target, his diet has been established according to foods that he accepts and it was distributed into 5 meals (3 main meals and 2 snacks). Every day we discussed the diet for the next day.

The negotiation of diet was difficult, we gradually increased the amount of food and we introduced new foods.

We focused on proteins and not on carbohydrates. If we had insisted on introducing carbohydrates we would not have compliance.

The purpose was not to increase the weight quick, it was to decrease the physical effort.

Psychopharmacological treatment consisted in associating an SSRI antidepressant (which was administered mainly for his obsessive ideas, than for depression) and an atypical antipsychotic, also given for his obsessive ideas, and for his secondary effect of increasing appetite.

The psychotherapeutic treatment consists in supportive therapy, cognitive-behavioral and family therapy with the establishment of a patient-psychiatrist therapeutic relationship, the therapeutic alliance being an important mediator for the therapy success.

Family therapy was also found as an effective treatment for adolescents with anorexia [3] and especially a well established method widely used with positive results in clinical improvement over time.[8]

Family-based treatment has been shown in randomized controlled trials to be more successful than individual therapy in most treatment trials.[9] Several components of family therapy for patients with anorexia nervosa are:

- the family is seen as a resource for the adolescent [10];
- anorexia nervosa is reframed in benign, non blaming terms [10];
- directives are provided to parents so that they may take charge of their child or adolescent's eating routine [10];
- a structured behavioral weight gain program is implemented [10];
- after weight gain, control over eating is gradually returned to the child or adolescent [10];
- as the child or adolescent begins to eat and gain weight, the therapeutic focus broadens to include family interaction problems, growth and autonomy issues and parent–child conflicts[10].

Cognitive behavioral therapy (CBT) is an evidence based approach which in studies to date has shown to be useful in adolescents and adults with anorexia nervosa. [11]: Components of using CBT with adults and adolescents with anorexia nervosa have been outlined by several professionals as:

- the therapist focuses on using cognitive restructuring to modify distorted beliefs and attitudes about the meaning of weight, shape and appearance[10];
- specific behavioral techniques addressing the normalization of eating patterns and weight restorations, examples of this include the use of a food diary, meal plans, and incremental weight gain [10];
- cognitive techniques such as restructuring, problem solving, and identification and expression of affect [10];

When using CBT with adolescents and children with anorexia nervosa, several
professionals have expressed concerns about the minimum age and level of cognition necessary for implementing cognitive behavioral techniques [10]. Modified versions and elements of CBT can be implemented with children and adolescents with AN. Such modifications may include the use of behavioral experiments to disconfirm distorted beliefs and absolutistic thinking in children and adolescents [10].

**Evolution And Prognosis**

Positive prognostic factors were:
- under 18 years old;
- lack of previous hospitalizations;
- absence of purging behavior.

Negative prognosis factors:
- the association with the obsessive personality disorder.

Further evolution of the patient was slowly favorable, he reduced the intense physical effort (not playing football so often and not traversing miles and miles through the city) and also he took weight 1 pound in a month. The fact that he was a perfectionist was helpful for us on one hand because he strictly followed the rules we set, but on the other hand he gave us many obstacle because he hardly accepted a new food or increasing the amount of food.

**DISCUSSIONS**

What is particular in this case is the presence of anorexia in males, considering that anorexia nervosa is more common in teenage girls, although lately we observed that the cases of anorexia nervosa in men are growing. It seems that males are coming much harder to doctor and only when there is a marked decrease in weight or severe depression with autolytic ideation [12]. Is not unusual for men suffering from an eating disorder to suffer also of alcoholism and / or drug abuse (though many women also suffer both eating disorder and substance abuse) [12].

Although overall the prognosis may seem favorable, this is not the case for all patients with anorexia nervosa. Among psychiatric disorders, anorexia nervosa has one of the highest mortality rates because of side effects of the disorder, such as cardiac complications or suicide. In intermediate to long-term studies with juveniles, death rates, on average, have ranged anywhere from 1.8 to 14.1% [13]. Recovery can be lifelong for some; energy intake and eating habits may never return to normal [14]. Many studies have attempted to study relapse and recovery through longitudinal studies but this is difficult, time consuming, and costly. Recovery is also viewed on a spectrum rather than black and white. According to the Morgan-Russell criteria patients can have a good, intermediate, or poor outcome. Even when a patient is classified as having a "good" outcome, weight only has to be within 15% of average and normal menstruation must be present in females. The good outcome also excludes psychological health. Recovery for patients with anorexia nervosa is undeniably positive, but recovery does not mean normal [13].

**REFERENCES**

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