Anorexia Nervosa
Case Study

Overview

Anorexia nervosa (AN) is a psychiatric illness with serious physical consequences resulting from malnutrition. Affected patients may demonstrate poor linear growth, reproductive dysfunction, low bone density, and impaired cardiac function and orthostatic intolerance, among other problems. Anorexia nervosa has the highest mortality rate of any psychiatric illness, reported at up to 5 percent in adults. Although mortality in adolescents is much lower, morbidity related to physical symptoms and severely impaired psychosocial functioning is significant.

Patients with anorexia nervosa have variable presentations. In classic cases, patients are severely underweight. However, a growing number of cases are diagnosed in formerly obese patients who have lost weight inappropriately.

The following case study shows how the Partial Hospitalization Program and family therapy-based approach used in the Nationwide Children’s Hospital Eating Disorders Program can support recovery.
**2012**

Carrie* is a female patient who first came to Nationwide Children’s at age 12. She was diagnosed with depression and anxiety. She was engaging in food restriction but did not have body image distortion. She had not lost weight, and her BMI was near the 50th percentile. Her treatment included medication (fluoxetine 20 mg daily), outpatient therapy and nutritional counseling. After improvement, she stopped coming in for treatment.

Carrie’s parents brought her back to the Eating Disorders Program, at which time she endorsed poor body image, was exercising excessively and restricting her food intake. She was lying to and manipulating her family to support her compulsive exercising and food restrictions. Her BMI had dropped from the 73rd percentile to the 33rd percentile in one year. She was diagnosed with anorexia nervosa.

“She was engaging in some classic behaviors, such as hiding food and exercising in bed,” says Erin McKnight, MD, Adolescent Medicine physician at Nationwide Children’s. “Based on her behavior and the severity of her weight loss, we admitted her to our Partial Hospitalization Program.”

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**Partial Hospitalization Program (PHP)**

Carrie’s parents removed Carrie from school in order to participate in PHP, which includes over 40 hours of treatment weekly. Carrie received support with her eating, individual and group counseling, medical monitoring and psychiatric care.

“Carrie struggled with intense distress and anxiety during the initial stages of recovery,” notes Kristen Armbrust, LISW, Carrie’s primary therapist in PHP. “She needed lots of guidance on when to use skills to cope with and reduce eating disorder behaviors and urges.”

Carrie’s parents participated in family therapy and received education and support in managing Carrie’s eating and behaviors at home. “Our care model focuses on treating and supporting the whole family,” says Dr. McKnight. “Carrie’s parents took what they learned in PHP and ran with it.”

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**Intensive Outpatient Program (IOP)**

After four weeks of PHP, Carrie stepped down to the IOP for the next six weeks. Three hours a day, four days a week, she participated in individual, group and family treatment activities, including family meals and family therapy. By decreasing the number of program hours from PHP to IOP, Carrie was able to return to school while she and her family continued to receive significant support from the care team.

“During this time, we focused on helping Carrie overcome her fear of certain foods,” says Kate Lorenz, RD, LD, Carrie’s dietitian. She also began taking more control and ownership of her own recovery, with her parents’ role gradually diminishing.

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**Outpatient Care**

Once Carrie transitioned out of IOP, she continued her care in the outpatient setting. She saw a therapist weekly, a dietician and physician every two weeks, and psychiatrist monthly to quarterly. As her recovery progressed, the frequency of her appointments decreased. She is now seeing her therapist every two weeks and physician every three months. She no longer follows up with a dietitian or psychiatrist.

*The patient’s name has been changed to protect privacy.*
Achieving and Maintaining Healthy Growth

Determining a child’s target weight range involves many factors. Childhood growth charts are valuable in determining future growth goals. If the child consistently tracked along the 30th percentile for BMI before the eating disorder, resumption of growth along that trajectory is an appropriate goal. Other factors in determining a goal weight are return of menstruation, resolution of physical findings of malnutrition and improved cognitive functioning.

For Carrie, before the eating disorder, her weight tracked along the 50th percentile. At admission to PHP, she had fallen to the 25th percentile. During the first months of treatment, her weight fluctuated above and below her target percentile. It has since stabilized at around the 50th percentile.

Empowering Parents

A major component of the family-based care model is empowering parents to take control of the child’s eating behaviors at home. In the early phases of treatment, the parents control all food decisions and are coached in how to enforce adequate nutrition.

“We empower our parents to set and maintain boundaries,” says Dr. McKnight. “They leave the program knowing how to fight the eating disorder and set appropriate boundaries to help their children.”

Long-Term Success

As Carrie’s physical and mental health improved, she was able to take on more responsibility for her own food choices. “Carrie is now recovery-focused, making all of her own food choices and communicating triggers and concerns for relapse,” says Ms. Armbrust.

Carrie has now maintained her goal weight for over a year. For the last two summers, Carrie has attended sleep-away camp. Her family worked closely with the camp staff and the team at Nationwide Children’s to have a nutrition plan in place for her. Carrie understood that attending the camp was a privilege, and she took the necessary responsibility for her health to make it successful.

“This is the ultimate goal of our family-based care model. When parents set boundaries, the child has a secure environment to heal and earn responsibility. This, combined with the nutritional, medical and psychiatric care of the team at Nationwide Children’s, is a recipe for life-long health and recovery,” says Dr. McKnight.
Referrals to Nationwide Children’s Eating Disorders Program

Composed of experts from Adolescent Medicine, Behavioral Health and Clinical Nutrition, the Eating Disorders Program provides care for children and adolescents with eating disorders or disordered eating. The multidisciplinary team works together with the child and family to modify eating behavior, resume normal physical and psychosocial growth and development and address comorbid mental health concerns. When referred to the Eating Disorders Program, patients undergo a team diagnostic assessment performed by a Behavioral Health therapist, Adolescent Medicine physician, and dietitian. An appropriate treatment plan is developed for the patient. Patients recommended for PHP or IOP will be referred to the psychiatrist who will conduct an assessment and recommend the appropriate program.

To make a referral or get more information,
call the Eating Disorders Program at (614) 355-6300.