CASE REPORT

A Case of a Living Doll: A Case Report on Anorexia Nervosa with Co-Morbid Obsessive-Compulsive Disorder by Proxy

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Abstract

The authors report a case of co-morbid diagnosis Anorexia Nervosa (AN) with co-morbid diagnosis of Obsessive-compulsive Disorder (OCD) by proxy. The patient is a 16-year-old female who presented to the emergency department with features of AN and also OCD. To reduce the anxiety of her AN, she incorporated her mother as a proxy to follow specific instructions. The patient received both inpatient and outpatient support, and her condition gradually improved with antidepressants and antipsychotics. This case illustrates a co-morbid presentation of OCD with AN and also the result of family accommodation that led to the family member aiding with the compulsion. Treatment for the case was also briefly discussed.

Keywords: Anorexia Nervosa, Obsessions, Compulsions, Proxy

Introduction

In the DSM5, Anorexia Nervosa (AN) is coded as a restriction of energy intake relative to the individual’s requirement and causing significant low body weight. The restriction is a result of the abnormal beliefs of the individual’s body image and also an intense fear of weight gaining. On the other hand, obsessive-compulsive disorder (OCD) is coded as the presence of obsessions and/or compulsions that are distressing and causes impairment in daily functions.

A review on eating disorder co-morbidity showed that OCD in individuals with AN is common¹. The following case illustrates a patient with anorexia nervosa with co-morbid OCD by proxy. The patient’s OCD symptoms involved her mother as a proxy. The mother’s involvement is known in the literature as family accommodation.

Case Report

SL, a 16-year-old Chinese female presented to the emergency department with deliberate self-harm by cutting her own wrist and nine months duration of reduced oral intake, taking only one meal per day. Her meals would only consist of minimal amounts of vegetables that were insufficient for her daily calorific needs. She weighed 34kg on presentation and her BMI was 14. She also displayed other anorexic signs including hair loss, lanugo hair, and amenorrhoea. She harboured an intense belief that she was “not
skinny enough to be beautiful”. She was diagnosed as AN and subsequently admitted for medical stabilisation.

SL had one additional behaviour that differed from other eating disorders. While she did not restrict her mother from taking other foods, SL insisted on having her mother eat the same kind and amount of food that she was eating before she consumed her own portion. If the mother resisted, she would become physically abusive, or she would not eat for the rest of the day. She would also either deliberately cut her wrist or threatened to do so.

Worried about her wellbeing, her mother followed her accordingly. When her mother did that, SL would appear relieved and happy, and she would proceed to eat the same food. It was soon established that the behaviour was a result of SL having repetitive intrusive ruminations regarding how her mother need to pay attention to her by following her diet choices. The act of determining and setting up the meal for her mother was her ritual for reducing the rumination. There were no delusional beliefs revolving this particular behaviour. No other psychotic symptom was elicited. She was then diagnosed with OCD on top of her AN diagnosis.

In the ward, SL was provided nutritional rehabilitation to increase her weight and she was also started on antidepressants for her OCD. Later, she was also started on low dose Olanzapine to augment the effect of the antidepressant, to reduce the anxiety associated with the OCD and to aid with weight gain. Her family was also involved with her treatment.

With the intervention, the patient’s weight gradually improved and she was fit for discharge but the compulsive behaviour described above persisted. Over the course of the next few months, the behaviour worsened with the patient adopting new rituals. She started determining what clothes the mother would wear and she herself would wear similar outfits in terms of types and colour. She also started following her mother closely behind, insisting on being “the shadow of her mother”. Again, similar ruminations of needing her mother to provide attention to her by following the patient’s instructions were noted. Due to the distress from accommodating the patient, her mother developed anxiety and depressive symptoms that needed psychiatric intervention.

She displayed improvement with her ruminations once her antidepressants were increased to a high dosing (Tablet Sertraline 250mg daily). Her olanzapine dosage remained at low dose. During the last follow-up, she no longer displayed the rituals of controlling her mother. Her weight also improved to 49kg with a BMI of 20.

**Discussion**

Obsessive-compulsive disorder and eating disorder have been described to have possible overlapping phenomenological and neurobiological features. The grouping of these conditions is based on their phenomenological similarities with OCD, and their courses of illness, comorbidity and family history patterns, biological abnormalities, and treatment responses similar to OCD.

The cognitive behaviour theory of AN revolves around the theme of “self-control”. It is believed that individuals with AN exert high levels of “self-control” in their own diet in order to enhance their own self-worth. In the case above, SL expanded this theme of “self-control” onto her mother due
to the underlying OCD that she concurrently suffered. When this “self-control” is not exerted, anxiety emerges within the patient, as displayed in AN and OCD.

The family accommodation was thus performed by her mother in order to reduce the anxiety of both the mother’s and also the daughter’s. Studies have shown a relationship between symptom severity paediatric OCD and also family anxiety levels in family accommodation. The more severe the OCD symptoms that are perceived by the family, the more likely family accommodation will occur. The anxiety levels in the parents will also increase the likelihood of family accommodation.

Studies have also shown that Olanzapine has effect on the anxiety experienced by individuals with OCD and also provide support in weight gain for individuals with AN. This dual effect made it the most appropriate treatment to initiate in the patient in the case. While olanzapine did help with the patient’s weight stabilisation, her obsessions persisted until much later. It should be noted that in a review by Sareen et. al., antipsychotics have a bidirectional role of either reducing or worsening obsessive-compulsive disorders. The improvement is usually better with the additional prescription of a selective serotonin re-uptake inhibitor; while the worsening is usually due to an underlying primary psychotic disorder.

In summary, this case report illustrates a common co-morbid diagnoses of AN and OCD and the effect of family accommodation on the OCD. The use of olanzapine as part of the pharmacological management is also briefly discussed.

References


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