CASE REPORT

Melting down the Ice Queen: an integrative treatment of anorexia nervosa

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a.a.bartels@umcg.nl**SUMMARY**

A 23-year-old woman with anorexia nervosa (AN) and a strong need for control was offered an integrative treatment, empowering the patient to be an active participant and advocating shared decision-making. To emphasise this, both the therapist and patient describe their views on the therapy. The integrative treatment resulted in more psychological flexibility and behavioural improvements, as is evident from an increased weight, a decreased dietary restriction and an increased valued action. The strength of this integrative treatment is based on accepting and encouraging patient's self-chosen treatment method, within healthy limits, and thereby creating a flexible, supportive and empowering therapeutic alliance. More research is needed to test the efficacy of combining complementary therapies within conventional treatments of AN.

BACKGROUND

Integrative psychiatry is a relatively new approach within conventional mental healthcare.¹ It is based on the principles of integrative medicine and the contextual behaviourism or the third wave cognitive behavioural therapy. Integrative medicine is patient-centred, healing-oriented, emphasises the therapeutic relationship and embraces carefully selected conventional and complementary therapies.² The third wave treatments are characterised by openness to older clinical traditions, a focus on contextual and experiential changes and the construction of flexible and effective repertoires.³ To ensure a safe and effective use of complementary and alternative medicine (CAM) within mental healthcare, the Center for Integrative Psychiatry (a department of Lentis Mental Health Care) in the Netherlands designed a protocol in which, alongside conventional treatment, some carefully selected CAM therapies are offered under strict conditions.¹

This case study illustrates how the principles of integrative psychiatry can be applied to a patient with anorexia nervosa (AN). Integrative psychiatry involves patient-centered care and advocates shared decision-making as a preferred form of medical decision-making. In shared decision-making both the patient and professional engage in a rational discussion, resulting in a joint agreement about the treatment of choice. In this way, the patient will retain autonomy and is encouraged to participate in decisions.⁴⁻⁶ In accordance with these ideas both the therapist and patient have described their views on the treatment.

CASE PRESENTATION

Kirsten is a 23-year-old woman diagnosed with restricting-purging type AN and characterised as

having symptoms of obsessive compulsive personality disorder. Since age 17 she has a disturbed body image and a negative self-image. She occasionally begins to diet, to purge and to exercise excessively.

Since the age of 21 Kirsten is treated for her disorder by a self-employed psychologist and a dietician. Because of persisting symptoms the psychologist decided to refer her to the Center for Integrative Psychiatry.

At the time of the intake, Kirsten's diet is severely disrupted, she starves herself, purges and has an intense fear of becoming 'thick'. Her weight was just within the boundaries of normal weight, with a body mass index (BMI) of 18.6 (height 1.70 m, weight 54 kg), and menstruation was absent for 3 months. Owing to the disruption of her diet, she is rapidly losing weight. She refuses a conventional therapy and requests a customised treatment, which integrates mindfulness techniques. She is interested in Buddhism, which means to her a self-reflective and mindful lifestyle. Meditation has become an important part of her daily life. She believes in the self-healing capacity of human beings and is in search of the strength to balance herself.

TREATMENT

Kirsten was offered an integrative treatment, empowering her to be an active participant and advocating shared decision-making. To emphasise this, both the therapist (BMAH) and Kirsten described their views on the therapy. As the treatment was based on shared decision-making, no elaborate treatment plan was made. Details of the therapy are disclosed and discussed in the 'Results' and 'Discussion' sections.

OUTCOME AND FOLLOW-UP**Phase 1: building the therapeutic alliance**

Kirsten: 'I had formed an idea of how my eating disorder could be treated. First I needed to calm down my mind. My hypothesis was that if I calmed down my mind, normalising my diet would follow naturally. For me it was very important to figure out the meaning of my eating disorder. I knew for sure that it protected me from something, probably from painful feelings. If I could learn how to tolerate and cope with these feelings in a more healthy way, I might be able to let go of the eating disorder. I discussed these ideas with my psychologist. She listened in an open way and agreed to go along with them within certain limits. This was very important for me. It confirmed my own strength and wisdom and my ability to recover.'

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One of the most essential parts of integrative psychiatry is the therapeutic alliance. The results of nearly 40 years of research show that in psychotherapy the relationship is more important for the effect of a treatment than therapeutic orientation or technique.⁷ This is also true for the treatment of AN.⁸ To date, no specific therapeutic approaches have proven to be the most effective for the treatment of AN.^{9–12} Several studies show that both specific and non-specific therapeutic factors are important healing ingredients.^{13–14} In accordance with the patient's view, 'improving self-esteem', 'improving body experience' and 'learning problem-solving skills' are the most important therapeutic goals. The desired attitude of the caregiver should be supporting, empathetic and should be accompanied by clear rules.¹⁵ The therapist's investment in the self-confidence of the patient will promote change. Kirsten's refusal to normalise her diet as the first step in treatment made it important and necessary to build up confidence. She was allowed to have control over her treatment, under the condition that she would stick to the agreements on healthy behaviour. These agreements were: a weight limit of 50 kg (for a height of 1.70 m; BMI=17), no signs of self-inflicted cuts on body parts, coherent speech and sufficient concentration to have a conversation with her psychologist. If Kirsten should cross these limits, she would agree to focus on her basic nutritional needs to gain weight. In that case she would accept referral to an outpatient clinic specialised in eating disorders. There was a cooperation with her family doctor who weighed her every fortnight and would contact the psychologist in case the weight limit would be reached. We made a self-binding contract, signed by the patient, the psychologist and a psychiatrist of our department. The therapeutic team consisted of a psychologist, a psychiatrist, a dietician and a family doctor. The team members engaged in frequent consultation. In line with Kirsten's need for self-control she chose her own massage therapist, who was not employed at our centre.

Phase 2: creating awareness

Kirsten: 'I did not talk about food or weight in my therapy. Though, of course, I knew deep inside that I could only heal my eating disorder completely by normalising my diet. But inside me, the eating disordered part of me fought for its life. This part felt threatened, every time I talked about food or weight. I made mood boards with self-selected images to show my psychologist what was going on in my mind. She helped me to analyze the situation. I created some peace in my mind through daily practice of meditation and wrote poetry to express my feelings. Every fortnight I had an appointment with my family doctor, who checked my weight. I was extremely tense before these appointments and drank one to two litres of water and coffee before I was being weighed. I was particularly afraid of losing control of the treatment.'

Within the limits agreed upon, Kirsten had control over her treatment and the sequence of goals to be achieved. First, she wanted to understand her problems by formulating a hypothesis about the origin and persistence of her eating disorder. In formulating her hypothesis she used poetry and drawings, and realised she could relate to herself and others from different mind states. She chose symbols and gave names to these states. Psychoeducation helped her gain insight into functional and dysfunctional schemes. She called her most dominant and dysfunctional scheme the 'Ice Queen', a perfectionist who followed rigid rules, was overly critical and protected her against negative feelings. This corresponds with the model of Merwin *et al.*,¹⁶ who describes AN as a disorder of psychological inflexibility, characterised by an extreme need for control and intolerance of

uncertainty. 'Peace' was her healthy, adult state. From this onwards she had confidence, was flexible and was able to take responsibility. She chose the symbol of the Buddha, the observer stance characterised by focused, purposeful and flexible attention to all inner and outer experiences. In a diary she described experiences from the rigid stance, the 'Ice Queen', and from the flexible stance, 'Peace'.

Wanden-Berghe *et al.*¹⁷ found evidence supporting the effectiveness of mindfulness-based interventions in the treatment of eating disorders. To enhance her psychological flexibility Kirsten practised yoga and meditation. Techniques aimed at increasing psychological flexibility are part of the third wave cognitive behavioural therapy, which emphasises contextual and experiential change strategies such as mindfulness, acceptance and 'being in' the present moment.¹⁸ The mindfulness techniques helped her to ease her mind. Within a few weeks she had gained more insight and had calmed down her mind, without the feared increase in weight.

Phase 3: enduring suffering and nutrition management

Kirsten: 'My mind calmed down and I approached my minimum weight. In fear of losing control over the treatment, I decided that it was time to eat normally again. Together with a dietician I started to work on normalising my diet and food perceptions. She provided me with food guidelines and motivated me to normalise my eating habits. I became aware of my abnormal ideas about food and body size. This was an extremely difficult time. The anxiety of what would happen if I should have a normal diet was enormous. I used some medication (oxpam) prescribed by my family doctor to reduce my anxiety. At a certain point, the anxiety became so high, that I thought it would be better to give up. The relationship with my psychologist was good and our feelings of trust were mutual. I told her about my plans, knowing that she would listen, that she would never push me to do anything I did not want and that she would be honest in her feedback. Her reaction was indeed very honest and direct. She told me straightforwardly that it was not a good idea to give up now. She thought it was a waste of all the work we had done. She reminded me that I had said that this phase of normalising my diet was the most difficult part. The straightforward manner in which she talked to me, put me with both feet on the ground. I realised that I now faced the biggest challenge of my treatment, and that it would be stupid to give up after all those months of hard work. This gave me the strength to keep going on.'

Nutrition intervention, including nutritional counselling by a dietician, is an essential component of treatment of patients with AN.¹⁹ Just before reaching the minimum weight and imminent loss of control over her treatment process, Kirsten was willing to start this intervention. However, she remained ambivalent about the necessity. At this stage, both the patient and the therapist reaped the benefits of the confidence and cooperation achieved. It seemed that the supportive therapeutic attitude, with belief in her motivation and capability of change, was decisive for change.

Phase 4: conventional and complementary interventions

Kirsten: 'After about 3 months it was easier to eat. The anxiety I felt decreased. I was able to stop with the medication to reduce my feelings of anxiety. I got space and energy to rebuild my life. Maintaining a healthy diet was still difficult for me. The challenge at this moment was to eat varied and to go out for a dinner or for a lunch. Because I was eating properly, the weighing appointments with my family doctor became less frequently.

Eating gave me more energy. This energy enabled me to continue my classes and to exercise again. In order to get in touch with my body, I went to a masseuse who increased my body awareness. First, I felt a range of negative feelings, from disgust to fear. Through meditation I learned to remain present in these feelings. During therapy sessions I had to make drawings of my body to correct my unrealistic body image and we explored the negative thoughts about my body. I drew my perceived body image on a full size paper. Then I laid down on the paper and my psychologist defined the outline of my body. From the 'mindful Buddha stance', I named the differences between the two body outlines. The outline that I drew was much bigger than the real size of my body. I thus realised that my perception was not telling the truth about my body size. This helped me to attach less value to my own body perception.'

Integrative psychiatry has an open and critical attitude to all therapeutic disciplines and systems based on evidence-based medicine. In this phase of treatment we combined a cognitive behavioural intervention with a complementary therapy, namely massage therapy.

A consistent finding is that patients with eating disorders scrutinise their disliked body parts.^{20 21} Repeatedly scrutinising the body in a critical way can lead to fear of fatness and overevaluation of weight and shape.²²⁻²⁴ This body image disturbance is because of cognitive-evaluative dissatisfaction. In the cognitive behavioural strategy of drawing the body in both real and perceived proportions, the patient was helped to describe her body precisely and to examine the whole of her body in a neutral way to deemphasise negative evaluations. This technique is derived from Tuschen-Caffier and Delinsky.^{25 26}

In addition, massage therapy was applied. Massage therapy is an ancient method of treatment that is gaining popularity as a form of CAM and its largest effect is reduction of trait anxiety and depression.²⁷ In the current treatment, massage therapy further increased Kirsten's willingness to experience unpleasant emotions that were related to her body, such as fear and disgust, and decreased emotion avoidance and body dissatisfaction.

Phase 5: resources and committed action

Kirsten: 'I planned a trip to India and France with friends for the summer. I felt insecure about those trips for two reasons. First, I was not used to having any therapy for longer than two weeks, whereas those trips would take a period of seven weeks together. Second, during the last few years I had a lot of time alone and possibilities to retreat myself from people. Going to India and France would mean that there would always be someone around me. Together with my psychologist I explored which qualities I needed for both trips. Strength and courage were the most important positive resources and I learned to release my inner optimist by visualising myself as powerful and brave. During my trip I was continuously surrounded by people, which forced me to share my negative feelings. This brought a new experience. However, despite my fear of spending so much time with people, I was accepted. This meant a lot to me. After the trip I had some conversations with my psychologist, in which we discussed my successes. Currently, I do not have any eating problem. I don't know what I ate yesterday or last week. I don't know how much I weigh. I truly enjoy chocolate. It's not my size that determines my mood, and my weight fluctuates like my diet in a natural way.'

Most psychological treatments aim at shifting individuals with a mental disorder into a state of non-disorder. According to Huppert and Whittington²⁸ this is not sufficient. The authors suggest that positive mental states are more than 'the absence of

symptoms' and play an independent role in health outcomes. This emphasises the importance of promoting patients' strengths, resources and personal agency in the treatment of psychiatric illnesses. Strength-based approaches focus on empowerment, which is the process by which people gain some control over valued events, outcomes and resources to improve wellbeing. With guided imagery, Kirsten identified resources that could help her cope with aversive emotions related to purposeful action. At discharge, Kirsten had quit self-induced vomiting and self-harming, exercised daily for 1 h at the most, increased her weight to 63 kg (BMI=21.8) and was involved in valued action.

DISCUSSION

This case study illustrates the application of the principles of integrative psychiatry in the treatment of AN. The patient declined conventional treatment and preferred an integrative treatment in which she was given control over the treatment process (within limits). The therapy lasted for 12 months and consisted of the following phases: building a therapeutic relationship, creating awareness, enduring suffering, nutrition management, combining complementary interventions and finally connecting with positive resources and key values. The first phase lasted 1 month and the following phases lasted about 2 months each, with weekly sessions. In each phase the psychologist and client evaluated the outcome of the continuous process of the interventions. There are important limitations to this study. Firstly, it is limited to one case. However, the patient's encouraging comments merit further exploration and investigation. More case studies are needed to investigate the efficacy of integrative treatment for AN. Secondly, a limitation of integrative psychiatry is that it remains unclear which of the healing ingredients in treatment are effective, especially when combining complementary or alternative treatment with conventional treatment (such as massage therapy in this case). State-of-the-art research methods, developed by conventional science, will be needed to test CAM therapies.²⁹ Likewise, complementary or alternative medicine should only be recommended in case the patient prefers this and when these therapies have been proven safe and effective. This can be ensured by following the CAM-protocol, a stepwise process for advising carefully selected CAM therapies after conventional treatment for the disorder has been applied or at least suggested.¹

Yet, new approaches in the treatment of AN are needed, especially as to date no efficacious treatment is known, neither medical nor psychological.³⁰ This case study suggests that integrative psychiatry may contribute to a successful treatment of AN. Integrative psychiatry is based on the principles of integrative medicine and the third wave of behavioural and cognitive therapy. The third wave treatment interventions, such as mindfulness-based strategies, may be promising in the treatment of AN.³¹ In integrative psychiatry shared decision-making is the preferred model of clinical practice and the coauthorship of the patient can be regarded as an example of participation *pur sang*. The patient learned to identify and to mindfully observe her negative feelings, without responding to them behaviourally. This seems to have resulted in more psychological flexibility and behavioural improvements, with a normal eating and exercising pattern and a normal BMI (21.8) at discharge. The treatment consisted of different phases, but the most striking strength of the treatment presented above, may be the acceptance and encouragement of patient's self-chosen treatment method, thereby creating a flexible, supportive and empowering therapeutic alliance. In this view, the biggest challenge for a therapist is mobilising and supporting patient's innate self-curative

processes and daring to believe in the innate ability to change. Allegiance to this belief is perhaps more important than any commitment to a given approach.

Using the search terms 'anorexia nervosa', 'case report' and 'integrative treatment' did not reveal any similar cases. Omitting the last search term and limiting the search to the field of 'psychology' as from 2010, eight hits were retrieved, none of which described a similar treatment as the current case report.

Learning points

- ▶ Integrative therapy is a valuable addition to existing treatment methods for anorexia nervosa (AN).
- ▶ The integrative method will automatically stimulate therapy loyalty.
- ▶ AN patients with much insight may gain most from this method.

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REFERENCES

- 1 Hoenders HJ, Appelo MT, Van den Brink EH, *et al.* The Dutch complementary and alternative medicine (CAM) protocol: to ensure the safe and effective use of complementary and alternative medicine within Dutch mental health care. *J Altern Complement Med* 2011;17:1197–201.
- 2 Maizes V, Rakel D, Niemiec C. Integrative medicine and patient-centered care. *Explore (NY)* 2009;5:277–89.
- 3 Hayes S. Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behav Ther* 2004;35:639–65.
- 4 Sandman L, Munthe C. Shared decision-making and patient autonomy. *Theor Med Bioeth* 2009;30:289–310.
- 5 Stewart M. Towards a global definition of patient centred care—the patient should be the judge of patient centred care. *BMJ* 2001;322:444–5.
- 6 Anderson EB. Patient-centeredness: a new approach. *Nephrol News Issues* 2002;16:80–2.
- 7 Duncan BL, Miller SD, Hubble MA. *The heart and soul of change: delivering what works in therapy*. Washington DC: American Psychological Association, 2010.
- 8 De la Rie S, Noordenbos G, Donker M, *et al.* Evaluating the treatment of eating disorders from the patient's perspective. *Int J Eat Disord* 2006;39:667–76.
- 9 Bulik CM, Berkman ND, Brownley KA, *et al.* Anorexia nervosa treatment: a systematic review of randomized controlled trials. *Int J Eat Disord* 2007;40:310–20.
- 10 Hay P, Bacaltchuk J, Claudino A, *et al.* Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. *Cochrane Database Syst Rev* 2003;(4): CD003909.
- 11 McIntosh VVW, Jordan J, Carter FA, *et al.* Strict versus lenient weight criterion in anorexia nervosa. *Eur Eat Disord Rev* 2004;12:51.
- 12 Steinhausen HC. The outcome of anorexia nervosa in the 20th century. *Am J Psychiatry* 2002;159:1284–93.
- 13 Vanderlinden J, Buis H, Pieters G, *et al.* Which elements in the treatment of eating disorders are necessary 'ingredients' in the recovery process? A comparison between the patient's and therapist's view. *Eur Eat Disord Rev* 2007;15:357–65.
- 14 Noordenbos G, Seubring A. Criteria for recovery from eating disorders according to patients and therapists. *Eat Disord* 2006;14:41–54.
- 15 Button E, Warren R. Living with anorexia nervosa: the experience of a cohort of sufferers from anorexia nervosa 7.5 years after initial presentation to a specialized eating disorders service. *Eur Eat Disord Rev* 2001;9:74–96.
- 16 Merwin RM, Timko CA, Moskovich AA, *et al.* Psychological inflexibility and symptom expression in anorexia nervosa. *Eat Disord* 2011;19:62–82.
- 17 Wanden-Berghe RG, Sanz-Valero J, Wanden-Berghe C. The application of mindfulness to eating disorders treatment: a systematic review. *Eat Disord* 2011;19:34–48.
- 18 Segal ZV, Williams JMG, Teasdale JD. *Mindfulness-based cognitive therapy for depression*. New York: Guilford Press, 2002.
- 19 Ozier AD, Henry BW, American Dietetic Association. Position of the American Dietetic Association: nutrition intervention in the treatment of eating disorders. *J Am Diet Assoc* 2011;111:1236–41.
- 20 Reas DL, Grilo CM, Masheb RM, *et al.* Body checking and avoidance in overweight patients with binge eating disorder. *Int J Eat Disord* 2005;37:342–6.
- 21 Shafran R, Fairburn CG, Robinson P, *et al.* Body checking and its avoidance in eating disorders. *Int J Eat Disord* 2004;35:93–101.
- 22 Grilo CM, Reas DL, Brody ML, *et al.* Body checking and avoidance and the core features of eating disorders among obese men and women seeking bariatric surgery. *Behav Res Ther* 2005;43:629–37.
- 23 Reas DL, Whisenhunt BL, Netemeyer R, *et al.* Development of the body checking questionnaire: a self-report measure of body checking behaviors. *Int J Eat Disord* 2002;31:324–33.
- 24 Williamson DA, White MA, York-Crowe E, *et al.* Cognitive-behavioral theories of eating disorders. *Behav Modif* 2004;28:711–38.
- 25 Tuschen-Caffier B, Vogele C, Bracht S, *et al.* Psychological responses to body shape exposure in patients with bulimia nervosa. *Behav Res Ther* 2003;41:573–86.
- 26 Delinsky SS, Wilson GT. Mirror exposure for the treatment of body image disturbance. *Int J Eat Disord* 2006;39:108–16.
- 27 Moyer CA, Rounds J, Hannum JW. A meta-analysis of massage therapy research. *Psychol Bull* 2004;130:3–18.
- 28 Huppert FA, Whittington JE. Evidence for the independence of positive and negative well-being: implications for quality of life assessment. *Br J Health Psychol* 2003;8(Pt 1):107–22.
- 29 Barrett B, Marchand L, Scheder J, *et al.* Themes of holism, empowerment, access, and legitimacy define complementary, alternative, and integrative medicine in relation to conventional biomedicine. *J Altern Complement Med* 2003;9:937–47.
- 30 Agras WS, Brandt HA, Bulik CM, *et al.* Report of the National Institutes of Health workshop on overcoming barriers to treatment research in anorexia nervosa. *Int J Eat Disord* 2004;35:509–21.
- 31 Heffner M, Sperry J, Eifert GH, *et al.* Acceptance and commitment therapy in the treatment of an adolescent female with anorexia nervosa: a case example. *Cogn Behav Pract* 2002;9:232–6.

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