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Enema Abuse

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Enema abuse is a pernicious disorder, not extensively reported in the psychiatric literature. It may occur as an isolated paraphilia, klismaphilia (Denko, 1973, 1976), or as a symptom reflecting more pervasive illness or abnormality of attitude (Engel, 1975; Greenberg-Englander and Levine, 1981). Our patient had been using enemata excessively for sixteen years and presented in a state of cachexia; she had both obsessive-compulsive and affective symptoms, both frequently found in association with anorexia nervosa (Snaith, 1981).

Case Report

Mrs D., a 59-year-old, white, married mother-of-six, was referred because of severe, chronic weight loss. Extensive gastroenterological and endocrinological investigations had revealed no primary physical pathology, and the patient's condition was causing increasingly serious concern. In each of the preceding three years, the patient had been admitted to a general hospital, and on each occasion had been noted to have chronic constipation requiring laxatives and enemata for relief, was poorly nourished, nervous and hypokalaemic. In 1976, a psychiatric opinion had been sought, and involutional melancholia diagnosed; however, the patient only briefly tolerated 10 mg of the antidepressant doxepin. In 1977, her physician noted, "laxatives every day, 1–2 enemas a day, refuses to eat"; in 1978, she was "always wanting me to give her a diet that has no residue so that she won't have as much movement" and was living on "an inadequate diet—pancakes and rice".

Excepting mild asthma (since childhood) and hysterectomy at age forty, Mrs D.'s previous medical history was negative. She had a strict religious upbringing, and felt guilty about premarital petting with boyfriends. During her late teens, she occasionally self-administered enemata for constipation. She married at twenty (1941) and had her first child about a year later. During that pregnancy, she first experienced "bad thoughts" (that the figure on the crucifix on her bedroom wall was sexually attracted by her naked body) which had continued with varying intensity. Her husband first noticed her to be anxious when he returned from three years' military service in 1945. She had had two prior psychiatric hospitalizations, for four months in 1949 when she "cried a lot" and was given ECT (electro-convulsive therapy) and insulin shock, and for five weeks in 1951 when she again received ECT for anxiety, agitation and obsessive-compulsive symptoms. The obsessional symptoms continued and included contamination fears, preoccupation with "religious sins" and ritualistic handwashing routines.

In 1963, the patient reluctantly underwent hysterectomy; following the surgery, she began daily enema use. In the three years preceding the index admission, a number of stressful life events (dental clearance and marriage, divorce and deaths in the immediate family) occurred and enema use increased. During these three years, sexual relations stopped, and the patient ceased housekeeping in favour of hours spent in ritualistic personal hygiene. With her husband's assistance, she administered four to seven enemata daily, ate very little, was agitated and tearful, and devoted her entire waking life to washing and bowel clearance.

When admitted, Mrs D. was emaciated (152 cm, 29.7 kg) and had pitting oedema of the feet and ankles. She was tense and worried-looking; spontaneous talk was entirely about her bowels and her need for strong laxatives and enemas. She had no formal thought disorder, abnormal perceptions, or intellectual decline. She was anxious and mildly depressed, fearing bowel obstruction (delusional conviction of serious disease or curruption was not elicited). Obsessional thoughts and compulsive phenomena were present. Judgement and insight, particularly regarding her dangerously low food intake and weight, were poor. Routine laboratory studies were negative except for slight elevation of LDH (lactic dehydrogenase); chest x-ray showed moderately severe obstructive airway disease (unchanged in two years, as was the borderline electrocardiogram). Her MMPI profile suggested severe passive-aggressive orientation, difficulty with impulse control, and an excessive identification with the feminine role; there were manipulating, demanding features and indications of psychosomatic illness with secondary gain. The profile was described as pre-psychotic.

Differential diagnosis appeared to be between a severe obsessive-compulsive disorder and a late-onset anorexia nervosa. In hospital, Mrs D. was timid, dependent and demanding. She spent most of her time

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in repeated washing and lengthy denture hygiene. She importuned for laxatives and enemata, voicing fears that she would become obstructed. For this reason, she ate very little, losing a further 0.67 kg in weight and seemed oblivious to the dangers attendant upon her self-imposed starvation.

Treatment was multimodal, with behavioural techniques aimed at restoration of weight and more normal bowel function, backed by chemotherapy and reality-oriented, supportive psychotherapy. Initially, bedrest was enforced pending the achievement of a targeted weight gain, when limited bathroom privileges were restored. A maximum of one enema per day was made contingent on weight gain during the preceding 24 hours. Diet was supplemented with a high-protein, high-calorie drink between meals; these (which the patient initially only picked at and strongly resisted) were closely supervised by nursing staff, with firm persuasion and much reinforcement of appropriate eating. Intensive, supportive nursing care and reality-oriented psychotherapy were used throughout, along with instruction and assistance with thought-stopping techniques for her obsessional ruminations. Once the patient had reached initial weight targets and become ambulatory, time spent watching favourite television programmes and visits to the hospital beauty parlour were used to reinforce further gain. At first, a small quantity of chlorpromazine was prescribed, but the patient was unable to tolerate this; eventually, she was able to take a small dose of amitriptyline (10 mg four times daily), which had a mildly sedative effect and reduced the pressure of her obsessional symptoms a little.

The initial treatment period was stormy. Further weight was lost, Mrs D. resisted nutriment ("I know I should drink but I don't want to"), but after a week she began to gain weight. On day 10, the enema fluid was restricted to 1000 ml, and thereafter was reduced in volume by 50 ml on alternate days. On day 14, limited bathroom privileges were restored, though the patient expressed concern that she was gaining (weight) too fast. On day 43, the patient refused her enema because the timing clashed with a beauty parlour appointment; later that day, she had her first spontaneous bowel movement in several years. Thereafter her bowels moved, unaided, on an almost daily basis; she progressed to gradually extending passes home, husband having been clearly instructed regarding laxatives and enemata beforehand. On hospital day 68 (63 days after the programme began) the patient was discharged at a weight of 38.1 kg, with the clear understanding that failure to maintain weight or a relapse in bowel symptoms would result in re-admission.

Mrs D. has maintained weight in the 38–45 kg range, and has not required an enema, since. Her obsessional symptoms and bowel preoccupations have continued, with fluctuating intensity; an exacerbation of anxiety symptoms, withdrawal, and failure to cope followed upon the death of her husband, but enema abuse did not return.

Discussion

There are no similar reports of chronic enema abuse of this intensity. Diagnosis on presentation was complicated by the patient's cachectic but bright-eyed looks, near total food refusal, and preoccupation with purgatives and enemata, which made a diagnosis of late-onset anorexia very tempting. Obsessional features are common in anorexia nervosa (Snaith, 1981). DuBois (1949) even suggested that compulsion neurosis with cachexia was a more accurate term for the syndrome than anorexia nervosa. While typically occurring in females around the time of puberty, anorexia-like syndromes have also been described as occurring in adulthood (Kellett *et al*, 1976; Launer, 1978; Oyewumi, 1981). In each of these cases, obsessional traits were prominent, and excessive purgation was a feature of two of the three. Starvation tends to promote constipation, which may also be a preoccupation in (particularly elderly) persons with obsessional traits. Launer's (1978) patient was a lifelong consumer of proprietary laxatives, smuggled these into the hospital, and was preoccupied with constipation. A crucial difference between Launer's case and Mrs D. was their attitude towards the severe weight loss; the former denied her thinness, became increasingly intransigent as a weight target was reached, and contemptuously refused food during a trial dietary free-choice period; Mrs D.'s weight remained a secondary concern beside her fear of intestinal stasis, and weight gain in itself was not apparently a major concern: she was not engaged in the "relentless pursuit of thinness" (Bruch, 1977). Both women were of a very obsessional nature; however, Launer's patient had at no time displayed compulsive symptoms, whereas Mrs D. had a history of washing rituals which antedated by many years the enema abuse and weight loss with which she presented. It seems likely, therefore, that Mrs D.'s primary diagnosis was obsessive-compulsive disorder, with enema abuse and dependence as secondary phenomena.

The behavioural techniques used were similar to those used in the treatment of anorexia nervosa (i.e., the reinforcement of weight gain by gradual restoration of privileges and activities initially withheld during a restorative and restrictive period of bedrest). They were effective on lengthy follow-up. Using an undesirable behaviour, enema administration, as a

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reinforcer for desired behaviour (in this case, weight gain) is an uncommon reinforcement technique, but it can be extremely effective when the reinforcement repertoire is limited (Rincover *et al*, 1979). It can also be considered as a pacing technique, so that the behaviour gradually comes under therapist, rather than patient, control, and is therefore more amenable to modification in that the reinforcement schedule can be made gradually leaner by reduction in the volume of the enema fluid (1000 ml down to 350 ml). Thought-stopping was temporarily helpful to this patient, but needed constant supervision, the patient showing little motivation to continue the technique outside the therapeutic situation.

Psychotropic drug treatment was not dramatically helpful in this case. Mrs D. was extraordinarily sensitive to the medication side effects. Clomipramine, a tricyclic reportedly helpful in obsessional states, is not currently available in the USA. Amitriptyline has been used in the treatment of both anorexia nervosa (Moore, 1977) and obsessive-compulsive neurosis (Snyder, 1980) but was not of marked or lasting benefit in this case, possibly due to the small dose tolerated. While mono-amine oxidase inhibitors have also been used in obsessional disorders, it was judged that the associated dietary restrictions might exacerbate Mrs D.'s problematic eating habits. Minor tranquillizing agents were only temporarily helpful because of intolerance of sedative effects and speedy habituation to small doses. Current medication is maprotiline, the low anticholinergic side effect profile of which has allowed a dose within the therapeutic range, with some relief of the patient's anxious dysphoria but unfortunately, little or no effect on her obsessional ruminations.

In addition to the rarely-reported variant of obsessive-compulsive disorder with severe enema abuse, Mrs D.'s case illustrates some of the difficulties involved in reaching a global diagnosis when so much secondary symptomatology stems from one behaviour; the versatility and effectiveness of behavioural techniques in modifying discrete behavioural abnormalities is again demonstrated.

References

BRUCH, H. (1977) Psychotherapy in eating disorders. *Canadian Psychiatric Association Journal*, **22**, 102–8.

DENKO, J. D. (1973) Klismaphilia: Enema as a sexual preference: report of two cases. *American Journal of Psychotherapy*, **27**, 232–50.

—— (1976) Klismaphilia: Amplification of the erotic enema deviance. *American Journal of Psychotherapy*, **30**, 236–55.

DUBOIS, F. S. (1949) Compulsion neurosis with cachexia (anorexia nervosa). *American Journal of Psychiatry*, **106**, 107–15.

ENGEL, G. L. (1975) Psychophysiological gastrointestinal disorders: II. Intestinal disorders. Pp 1643–4 in *Comprehensive Textbook of Psychiatry*, (eds. A. M. Freedman, H. I. Kaplan and B. J. Sadock). Baltimore: Williams and Wilkins.

GREENBERG-ENGLANDER, S. & LEVINE, S. B. (1981) Answers to questions: significance of frequent enemas. *Medical Aspects of Human Sexuality*, **15**, 116.

KELLETT, J., TRIMBLE, M. & THORLEY, A. (1976) Anorexia nervosa after the menopause. *British Journal of Psychiatry*, **128**, 555–8.

LAUNER, M. (1978) Anorexia nervosa in late life. *British Journal of Medical Psychology*, **51**, 375–7.

MOORE, D. C. (1977) Amitriptyline therapy in anorexia nervosa. *American Journal of Psychiatry*, **134**, 1303–4.

OYEWUMI, L. K. (1981) Is anorexia nervosa a disease of all ages? *The Psychiatric Journal of the University of Ottawa*, **6**, 39–42.

RINCOVER, A., COOK, R., PEOPLES, A. & PACKARD, D. (1979) Sensory extinction and sensory reinforcement principles for programming multiple behavior change. *Journal of Applied Behavioral Analysis*, **12**, 221–33.

SNAITH, R. P. (1981) Anorexia nervosa. In *Clinical Neurosis*. Oxford University Press.

SNYDER, S. (1980) Amitriptyline therapy of obsessive-compulsive neurosis. *Journal of Clinical Psychiatry*, **41**, 286–9.

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