Ghana Alternative Medicine Journal (GAMJ)
Abbreviated Key Title: Gha alt Med Jrnl
ISSN 2756-7176 (Print) Open Access
Journal homepage: https://saspublishers.com/journal/gamj/home

OPEN ACCESS

Male Anorexia Nervosa Comorbid to Depression: About a Clinical Case

Aicha Kouyed[1*], Bouchra Aabbassi[1], Imane Adali[1], Fatiha Manoudi[1]

[1]Team of. Mental Health Research Laboratory "Childhood, Health and Development

DOI: 10.36347/gamj.2023.v04i04.002 | **Received:** 09.09.2023 | **Accepted:** 13.10.2023 | **Published:** 20.10.2023

***Corresponding author:** Aicha Kouyed
Team of. Mental Health Research Laboratory "Childhood, Health and Development

Abstract **Case Report**

Anorexia mainly affects women, but there are also less common cases in men, which often remain underdiagnosed and can be very serious. It is important to note that the prevalence of male anorexia nervosa is increasing, ranging from 0 to 0.09. This disorder usually affects young girls aged 12 – 20 (1% of girls, 0.1% of boys), and can be responsible for massive weight loss (between 30 and 50% of the initial weight) aggravated by laxatives and diuretics, as well as serious somatic and psychological complications. This disorder typically develops during adolescence and reaches its peak between the ages of 14 and 18 years, the sex ratio suggested is about 1 man to 10 women, Anorexia nervosa is a complex illness that is caused by multiple factors, including genetic, developmental, sociocultural, familial, individual, behavioural and cognitive components. This disorder comorbid with depression is a complex medical condition that affects an individual's mental and physical health. This co-occurrence of disorders requires an integrated treatment approach, emphasizing collaboration between mental health professionals and patients themselves.

Keywords: Male anorexia, depression, comorbidity.

INTRODUCTION

Anorexia nervosa is defined according to the DSM 5 as a refusal to maintain a body weight considered normally minimal, resulting in a weight loss of less than 85% of the expected weight for height and age; an intense fear of gaining weight a significant alteration in the perception of one's own body and a denial of the seriousness of current thinness, even in the presence of weight loss and its consequences ; and for post-pubertal women, the absence of menstruation for at least three months. There are two types of anorexia nervosa, namely the restrictive form (AM-R) and the form with binge eating, vomiting and taking laxatives (AM-B). This disorder usually affects young girls aged 12 – 20 (1% of girls, 0.1% of boys), and can be responsible for massive weight loss (between 30 and 50% of the initial weight) aggravated by laxatives and diuretics, as well as serious somatic and psychological complications. This disorder mainly affects women [1, 2], but there are also less common cases in men, which often remain underdiagnosed and can be very serious [1]. It is important to note that the prevalence of male anorexia nervosa is increasing, ranging from 0 to 0.09 [4], This could be explained by the fact that men may also be subject to socio-cultural pressures to achieve an ideal of beauty or masculinity, which can contribute to the onset of anorexia nervosa, Media, advertising, and social expectations regarding physical appearance may play a role in the development of the condition. Individual factors such as genetic predispositions, a family history of eating disorders or depression, and pre-existing mental health conditions can cause this disorder in men. The comorbidity between anorexia nervosa and depression is relatively common. People with anorexia nervosa have an increased risk of developing depression due to the stressors and emotional disorders associated with their eating disorder [3].

CLINICAL CASE

Adam, 16 years old, only child of his parents, enrolled in the 3rd year of secondary school with a good academic performance, whose developmental history is unusual. The family dynamic is marked by a divorce of the parents for 2 years, the father is a drug addict (cannabis addiction), with a great impact on his family and professional life. Adam has no contact with his father after the divorce, while he has a close relationship with his mother. The adolescent does not present with any psychiatric ATCD, referred by the general practitioner of the health center for eating disorders causing significant weight loss (65kg _ 37.5kg _ 27.5 kg / 3 months) with an

incessant request for medication to help him lose weight. Since 3 months, insidious onset with progressive worsening of the symptomatology characterized by quantitative dietary restriction: prolonged fasting without bouts of hyperphagia, no induced vomiting or purgative behaviors (no use of laxatives, diuretics), great self-guilt and excessive crying after meals, a relentless search for medication to lose weight, excessive concerns around body image, weighing every 2 days, physical hyperactivity. Camouflage behaviours on certain parts of his body (he puts bandages on his breasts so that they do not grow, he always sleeps on his back so that his buttocks do not develop), attitudes of daily checking of his body in front of the mirror, with wearing wide clothing.

The adolescent begins to show depressive symptoms: social withdrawal, corporo-clothing neglect and expresses thoughts of death on a recurrent basis, without suicidal scenario with anxious ruminations in the evening about his weight. Interview finds a teenager, Anxious, suspicious, Reluctant, Denial of the seriousness of his disorder, concerns about weight and diet, Asks for a diet pill and for increase height too, Self-esteem is impaired, No suicidal intentionality, No psychotic symptomatology. Pale yellow complexion, Good constants, Temperature = 37.2, HR = 75 btm/min BP = 110/80 mm Hg, He weighs 38.5 kg for 1.61 m (BMI at 14.86). Additional examinations including a biological assessment and an ECG that does not reveal any abnormalities. At the end of these investigations, the diagnosis of restrictive anorexia nervosa was retained with depressive comorbidityPharmacological treatment: Sertraline, psychotherapy, management of his somatic state.

DISCUSSION

Anorexia nervosa is an eating disorder that mainly affects young girls in adolescence, the proportion of the general population suffering from anorexia nervosa is estimated to be between 0.5% and 3%. This disorder typically develops during adolescence and reaches its peak between the ages of 14 and 18 years, the sex ratio suggested is about 1 man to 10 women [1], Anorexia nervosa is a complex illness that is caused by multiple factors, including genetic, developmental, sociocultural, familial, individual, behavioural and cognitive components [2]. It tends to manifest itself mainly during adolescence [4], a period marked by questions about identity [4] and readjustments in social and family relationships [2]. Underlying family issues, internal conflicts, negative self-image, independence issues, and a sense of loss of control over one's own life are common elements associated with anorexia nervosa. In this context, dietary restriction can be seen as a way to gain a greater sense of control over one's personal life. Most studies on male anorexia have shown that male anorexia is less concerned about their weight and the search for thinness than female subjects, rather the search for an ideal male figure [2]. The main goal of weight loss would be to achieve visible musculature rather than the search for thinness. The most recent studies do not suggest major gender differences in the weight control strategies adopted by patients. The hypothesis that men have significantly more recourse to physical hyperactivity than women in anorexia cannot be affirmed. Male anorexia nervosa tends to be chronic [1]. Being a taboo subject in some cultures [3], patients are embarrassed to talk about it, because it is a generally female pathology [1], is at the origin of a great diagnostic error, in addition to the lack of hindsight and studies on this subject making diagnosis sometimes difficult. Severe depressive disorder is the most common comorbid disorder found in these subjects [3]. First of all, the anorexic syndrome itself is responsible for symptoms that mimic or partially overlap with the classic symptomatology of depression: low self-esteem, anxious ruminations, sleep disorders associated with sleep refusal related to hyperactivity and evening anxiety, Social withdrawal, which is often encountered in depression, is also common in anorexia nervosa.

Finally, suicidal ideation is common during PA. It should be noted that they are not specific to a characterized thymic pathology, especially when they occur in adolescence, but must be screened and monitored. Severe depressive disorder and melancholy are particular presentations in anorexia nervosa that can be life-threatening in the face of the high risk of suicide, aphagia, or even global refusal syndrome. There is an imperative to quickly identify severe depression in adolescents suffering from anorexia nervosa in order to propose, together with renutrition, treatment. Given the frequency and potential impact of MDE [5, 6], with suicidal risk and a derogatory course, any global assessment of patients with MA should include systematic investigation of this comorbidity. Other psychiatric comorbidities found in various studies such as: Anxiety disorders, Personality disorders, Substance use disorders, psychotic disorders [5]. Male anorexia nervosa is often linked to sexual orientation disturbances [1]. Homosexuality in the male population is a risk factor for developing eating disorders. Figures have been proposed concerning the frequency of homosexuality in anorexic men: it could concern between 25% and 58% of subjects. A review published in 2016 by Castellini et al. Focused on the sexuality of patients with eating disorders. They found numerous studies indicating a greater risk of developing eating disorders in gay or bisexual men. Some studies have shown that gay and bisexual populations experience more stress, which is more likely to lead to pathological eating behaviours. They also point out that several studies have observed that gay and bisexual men develop significant bodily concerns compared to heterosexual men, leading them to want to achieve a physical ideal (thin, muscular, youthful body) to attract a partner. Gender dysphoria in the male population suffering from anorexia nervosa is regularly mentioned in the literature as a comorbidity or risk factor

for the disease, but in the end very little documented, and does not allow a conclusion to be drawn in this direction.

CONCLUSION

Male anorexia nervosa: rare but severe. Anorexia nervosa prevention axes in the future will have to combat the significant stigma around eating disorders, which are considered typically female, which would allow both adolescents and men to facilitate their request for care. Depressive comorbidity is often found in anorexia nervosa, and antidepressants are frequently prescribed.

REFERENCES

1. Serie, C., Mainhagu, P. (n.d). Michel de Boucaud a Service de me´decine interne et post-urgences, centre hospitalierPellegrin, universite´ de Bordeaux, CHU de Bordeaux, place Ame´lie-Raba-Le´on, 33076.
2. Jue Chen, Fang Zhang, Marie-Rose Moro. (n.d). Marion Vu-Augier de Montgrémier (Interne DES psychiatrie, stagiaire au Shanghai Mental Health Center
3. Corbeil-Serre, L., Meilleur, D., Turgeon Laboratoire des troubles de la conduite alimentaire, département de psychologie, université de Montréal, CP 6128 succursale centre-ville pavillon Marie-Victorin, H3C3J7 Montréal, Québec, Canada
4. Richard, E., Glezer, D., Samuelian, J.C. (2013). L'EMDR dans la prise en charge du psychotraumatisme, présentation et incidences médicolégales. Rev Fr Domm Corp., 2, 141–53.
5. Bercé, C., Vinay A., Nicot, E. (n.d). Laboratoire de psychopathologie et de psychologie médicale, université de Bourgogne, 12, avenue de la Concorde, 21000 Dijon, France
6. Kountzaa, M., Garyfallos, G., Ploumpidis, D., Varsouc, E. (n.d). Gkiouzepas b a Unité de soins pour les troubles des conduites alimentaires, ANASA, Siggrou 36–38, 11742.