

CLINICAL PATTERNS OF ANOREXIA NERVOSA DEPENDING ON AGE

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Abstract: Anorexia nervosa is defined as a psychopathologic syndrome with varied etiology, characterized by self imposed, drastic and selective limitation of the individual's diet, determining a significant loss of weight, metabolic disorders and severe hydro-electrolytic lack of balance, all of which put life in danger. The positive diagnosis of anorexia nervosa is based both on the symptomatic triad: anorexia, significant weight loss and amenorrhea (with the equivalent of amenorrhea in men: decrease of libido and erection) and on the absence of an organic etiology or of a psychic disorder (depressive disorders, schizophrenia etc.). Anorexia nervosa usually makes its debut in puberty and adolescence, very seldom before the age of 10 and over the age of 30.

Keywords: anorexia nervosa, clinical patterns

Rezumat: Anorexia nervoasă este definită ca un sindrom psihopatologic de etiologie variată, caracterizat prin limitarea autoimpusă, electivă și drastică a dietei, care conduce la o pierdere marcată a greutății corporale, tulburări metabolice, dezechilibre hidroelectrolitice severe care pot pune viața în pericol. Diagnosticul pozitiv al anorexiei nervoase se bazează pe triada simptomatică: anorexie, scădere ponderală semnificativă și amenoree (cu echivalentele amenoreei la bărbați: diminuarea libidoului și erecției), dar și pe absența unei etiologii organice sau a unei tulburări psihice (tulburări depresive, schizofrenie etc). Anorexia nervoasă debutează în mod obișnuit în perioada de pubertate și adolescență, foarte rar înaintea vârstei de 10 ani și peste vârsta de 30 ani.

Cuvinte cheie: anorexia nervoasă, forme clinice

INTRODUCTION

Child's Anorexia

The infantile psychic anorexia comes as a consequence of simple anorectic factors: pain, respiratory difficulties that hinder food's ingestion, eating between the main meals of the day, depressive mood, mother's anxiety and her tendency to have her child eat as much as possible, doubled by the child's tendency to get rid of the mother's overprotection, disharmonious relationships and/or lacks of educational-emotional and food type.

The intervention by force and punishment in

psychic anorexia inhibits even more the hunger-appetite mechanism, both through reactions of anger and protest, and through negative emotions of frustration. In such cases, the child's preferences should be attentively analyzed. Also, the child should not be forced to eat only the food that the parents consider it good.(3)

Infant anorexia represents a clinical concept different from the typical adolescence anorexia.

The precocious anorexia of the infant is rare; it may appear in the first days or weeks after birth. Initially, it may take the form of passive attitude towards food, the child lacks cooperation, sometimes he/she does not swallow or the milk loops over the lips - the so called inertia anorexia, so that, after some time, the infant could oppose. The infant is agitated, screams, refuses to drink, to swallow, throws up what has been swallowed, turns the head in front of the teaspoon, plays with the food without eating - the so called opposition anorexia.

These are the means used by the infant in order to refuse the food he/she is offered. The infant does not put on weight or the loss of weight is not significant, in the absence of somatic-psychic suffering.

The eruption of teeth may favour the installation of temporary anorexia.

It is important to make the difference between "normal" and "pathologic", because in this process of "offering and receiving" food, difficulties may occur that may or may not be surpassed by the mother - child couple.(1) Food offering by the mother and the child receiving it represents the beginning of mother - child relationship and it is a fundamental and extremely important process. Persisting in mistakes in the period of food offering, with the occurrence and the increase of emotional tensions and the installation of the refusal to eat, may bring about the appearance of abnormal eating habits in time.

The mother's anxiety is the most important and justifies her need for help. Solving the mother's problems makes disappearing the child's anorexic behaviour in most of the cases.

The anorexia of the 2nd semester

The anorexia of the 2nd semester is more frequent. It appears in months 5 - 8 when the milk is eliminated and a varied diet is introduced. Within this

period, there is a physiologic liability of the appetite, when important changes occur in the infant's development.

KREISLER and his collaborators (1966) distinguish two types of anorexia of 2nd semester:

1) simple anorexia, which appears as a refuse of food, being installed at a probably very basic level, and not at the level of disorder of hunger and appetite;

2) the so-called complex anorexia, which is signalled by the intensity of the symptom and its resistance to usual treatment methods. The child behaves as if food did not interest him/her. This anorexic child is different from the child who eats little because of his/her constitution, that case becoming obvious much earlier.

Rarely, these babies later present sphincter disorders, sleeping disorders, reactions, such as sobbing spasms, behavioural disorders.

The anorexia of the second childhood

The anorexia of the second childhood is often a continuation of the anorexia from early childhood, but it may also appear in the case of children with no antecedents of eating behaviour disorders, in the case of children fed normally during the first year of life.

It is organized either in the shape of opposition towards the rigidity of the parents (qualitative and quantitative exigencies, the strictness of the order of meals, the obligation to maintain the same rhythm as adults), or by the capricious way of choosing food pointing out phobic components. The evolution of this anorexia is usually not severe from the physiological point of view, but it often creates the subsequent eating behaviour model.

Prepubertal anorexia

It has a precocious inception, setting in between the age of 9 and 11, preceding the first pubertal signs, having a more severe prognostic. It is more frequently encountered in the case of persons with disharmonic personality traits and in those with affective deficiencies, boys being more affected.

This form is close to the types of anorexia associated with a delayed weight gain favoured by a decrease, usually reversible, of the growth hormone, close in profile with psychogenic dwarfism, also known as frustration dwarfism. In general, anorexics have a smaller stature than the test group.

Anorexia with pubertal inception comes about after the setting in of the first pubertal signs, before the first menstruation. The diagnosis is not different from the classical form.

The anorexia of the adolescent

It is the most frequent form of anorexia nervosa. The clinical presentation, the debut age, characteristic to adolescence, the significant prevalence in the female gender and the excessive weight loss by the reduction of food consumption are essential elements of this disorder with a rich psychopathological and somatic polymorphism.(7)

The essential elements of anorexia nervosa are the following: the effort to maintain body weight under

the normal minimal limit corresponding to age and height (the weight loss is obtained by a drastic reduction of the food intake, provoked vomiting, abusive use of purgatives or diuretics and excessive and durable physical efforts), the excessive fear of gaining weight or of becoming obese (even if the person is underweight), the deformed perception of corporal image, amenorrhea (in the case of women).

Late onset anorexia (anorexia of the mature adult)

Anorexia nervosa of the adult female must be distinguished from the adolescents' form, which extends to adult age.

The adult form is encountered mainly in the married women, quite frequently being preceded by a minor and transitory anorexic episode in adolescence. Usually, late onset anorexia has as triggering and favouring factors the marriage, the birth of a child, the disharmonic partnership relations. The psychopathologic presentation is marked by the presence of depressive disorders with melancholy and/or hypochondriac elements, while the wish to lose weight is in the background, and the addiction to the entourage is a particular trait of the frailty of their subjacent personality, phenomenon which we must take into account in ensuring an important therapeutic support.

Regarding the elderly, anorexic behaviours are rare. They occur as witnesses of the wish to die, due to their isolation, the loss of identity, multiple physical problems, of the impossibility to have a future.

An inception of intellectual deterioration is sometimes found upon examination.

Minor anorexia

It refers to the atypical forms, with a favourable evolution with or without medical care, with a duration of a few months, without excessive weight loss, sometimes without complete amenorrhea, accompanied by bulimic episodes, vomiting, disorders of the corporal image. These clinical forms may remain undiagnosed.

They are the most numerous, often escaping statistics, as they rarely become the object of specialized consultations and even less, of hospitalizations. They are in reality at the borderline of the pathology of eating behaviour disorders, especially if we take into account the importance of the socio-cultural pressure in favour of slimness in our society. A disturbed eating behaviour and important preoccupations concerning weight are a frequent way of reacting to the existential difficulties of adolescence.(2)

This form must be known because it does not need abusive medication and psychiatric therapy, which may lead to the conflicts and dramatization of a benign eating behaviour, thus augmenting this behaviour of opposition.

Male anorexia

Encountered very rarely, it is characterized by the frequency of the severe forms, with severe prognostic, which has led to the name of psychotic anorexia, having in view the schizoid, obsessive, phobic, hysterical

personality traits often encountered, in opposition with the female neurotic anorexia.(5)

Some studies carried out by ORGIAZZI BILLON-GALLAND and CHAPPAZ (6) report a certain frequency of anorexia nervosa with homosexuals, studies which need further research.

Although the clinical presentation of male anorexia nervosa is approximately identical with that of the females; it still shows some particularities: inception during preadolescence and adolescence against the background of a delay in physical and genital development, with a tendency towards withdrawal and isolation, the diminution of the capacity to create and maintain long-term interpersonal relationships.

Certain authors consider that there is a difference between female and male anorexics concerning hyperactivity; it is part of the clinical presentation of mental anorexia of young women, while in the case of boys, there is a predominance of apathy and passivity.

The diagnosis is given on the basis of the presence of the erroneous perception of the body image and of the uncontrolled wish to lose weight.

WOODSIDE et al. (8) prove that men start out from a superior weight, but the percentage of weight loss in mental anorexia is not different in the case of men, as compared to women.

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