# Anorexia Nervosa in Men

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## INTRODUCTION

Anorexia nervosa develops by preference in women at puberty. It is a serious nervous condition in which the patient refuses to take food because of her aversion to maturation, and as a result, becomes abnormally emaciated. This disease is considered to be nonsomatic or psychogenic.

The majority of patients are women and reports about male cases are few. In Japan, there were only three male cases reported on, by Shimosaka[1] and Fujimoto et al.[2] According to these reports, male cases present clinical symptoms different in nuance from female cases.

Recently, we encountered a male case of what is considered to be anorexia nervosa, and in the present report we have taken it up for discussion.

## CASE REPORT

Case: Male, aged 19 at the first medical examination.

He was living with his grandparents and mother.

Hereditary history: Not contributory.

His father, a carpenter, died of pulmonary tuberculosis when the patient was 4 years old and his grandfather, likewise a carpenter, has been bedridden for the past ten years due to hemiplegia after a cerebral hemorrhage. His mother is unsociable and of nervous temperament. She is running a grocery shop along with a strong-minded, active and nagging grandmother. They are of the standard build.

Past history: Easy delivery at full term with a body weight at birth of 2800 g. He was bottle-fed because of insufficient mother's milk.

Growth history and present illness: As a child, he was gentle, and spent most of his time playing with his sister who was five years older than he.

He was in the lower half of his class in respect to academic achievement in elementary school, and was in all respects unexceptional.

From around the time he entered junior high school, he had a keen appetite, grew remarkably in stature, and on graduation, as a third-year student, he was 180 cm in height and 67 kg in weight. However, he had little physical strength and as poor at sports, about which he was often teased by his classmates and the teacher in charge.

After graduation from junior high school, he joined a woodworking plant nearby. Even though working there was his own idea, was often absent, saying that the job is too hard, and that his senior workers scold him for his being slow in learning the work.

During this time, he had a spell of nausea, vomiting and diarrhea and his appetite diminished. His body weight dropped 5 kg in one month to 60 kg.

He saw a number of physicians, but the diagnosis were varied, e.g., "gastric ptosis", "chronic enteritis", "chronic appendicitis" and "hypothyroidism". As a result, he did not receive comprehensive treatment.

He quit his job after one year, and after that would watch TV at home, or help his mother in the family occupation, when in the mood to do so.

In the meantime, he became increasingly fastidious about food and ate only a very small amount of food at each meal. But he liked soft drinks and confectioneries and would secretly eat them between meals.

In the spring of his nineteenth year, he saw an internist because of dizziness and general fatigue, and after a week's hospitalization for a medical checkup, he was told that there was no evidence of any internal abnormality, and was referred to the Department of Neuropsychiatry, Yamaguchi University for admission.

Findings on admission: 182 cm in stature and 45 kg in weight. Body hair in the armpit and pubic area was thin. He had no beard, and a round face. The secondary sex characters were delayed, for his age. No abnormalities, other than disorders due to malnutrition, such as a blood pressure of 98/60, mild anemia, and a decline in serum protein were observed.

Examination of various hormones showed no abnormality and EEG findings were normal.

For his age, he was childish, spoke in a flattering way and was often seen walking after nurses in the ward.

Course of hospital treatment: Since the patient complained of

epigastric pain and diarrhea, and refused meals, substitution infusion was performed and anti-anxiety drugs and a protein anabolic hormone were administered. In taking the drugs, he often spit it out, and when reminded about it, tears often welled up in his eyes.

Three days after admission, an intramuscular injection of insulin was given in the morning and evening in five unit doses and alimentation through the nasal cavity was started.

The patient hated alimentation for the first week, and it could not be performed successfully unless the physician in charge took a coercive attitude, saying, "If you don't take it, you may die of malnutrition". After the first week, the rejecting attitude disappeared, but inversely, he fell into a completely passive state during nasal alimentation. So, we told him we would not allow him to watch TV or to see his family unless he ate meals on his own.

Although he said, "Vegetables do not digest well", "An egg contains plenty of cholesterol" and "Milk causes diarrhea", he came to eat about half of the meal, slowly, once a day. But he would sometimes take cakes given by other patients, avoiding the eyes of the nurses.

At the 5 th week, his body weight had increased to 50 kg and his general activity improved. He was sometime seen playing Japanese chess with old patients and telling a few jokes.

From around that time, he began talking slowly about his family and events in his senior high school days. Vexed at his tall stature, he said, pathetically, that he was teased about it many times, and murmured, with downcast eyes, "I'm good for nothing because I'm poor in sports and have no brain". In fact, he could not defeat even an old patient in a ping-pong game in the ward, and his grip strength was weak.

As to the increase in body weight, he merely said, "If I get fat, I'll become slow in action".

In an interview with his family members, he did not say a word, curled himself up, merely nodded to his grandmother, and behaved like a schoolboy to his mother.

At the second month of admission, he sometimes threw away food or did not take his drugs washing it away in the wash-room, but gradually began talking about his plans for the future. "If I gain my physical strenghth back, I would like to help my mother and succed the family occupation. But I don't think I can go to the wholesale market for purchasing because I have no ability", he murmured.

On the other hand, however, he did not go so far as to ask for a

discharge, and would say, "It's not too bad to stay in the hospital for the rest of my life".

From the third month of admission, he was half forcibly made to participate in the horticultural work and agricultural work. Here again, no positiveness whatsover was observeda both the performance and efficiency of work were rated poor. But his body weight returned to the level of 58 kg and his complexion became healthy.

According to the Ink-Blot-Test performed immediately before discharge, he was markedly dependent and was living complacently in a regressive world; independence of action was insufficient and intellectual grasp was not good. He was impulsive, immature and lacking control of personality; immaturity and childishness were conspicuous.

WAIS; verbal test IQ 88, performance test IQ 80, Yatabe-Guilford test, "A" type.

Three month after admission he was discharged home, followed by occasional check-ups in the out-patient clinic.

We arranged that he would take charge of store deliveries at home, receive money in the form of a salary and pay the living expenses to his mother out of his salary. We also saw to it that his grandmother would not scold him too harshly and that someone would accompany him to the wholesale market so that he could make decisions on the kinds and quantity of goods to be purchased.

In the latter case, however, he is still retiring and our attempt proved unsuccessful.

Recently, he has stated showing an interest in the opposite sex, saying, "I'm shy when a young woman comes into my shop".

## DISCUSSION

Male cases of anorexia nervosa are rare, and in a review of literature by Fujimoto et al.[2], male cases numbered 97 (9%) out of 1073 cases reported from 1960 through 1975.

As characteristics of male cases, many mention distorted familly relations. That is, the mother-child bonding is strong and identification with father is insufficient (Decourt[3], Falstein et al.[4], Kunzler[5], Meyer[6]). While identification with the father is weak, a tendency to identify with females is strong, and it appears to bring about an action to inhibit maturity as a male in young men.

Other characteristics include; a rejection of food, though not as obstinate as in female cases, constipation, lowered sexual potency,

accelerated behavior, apathy, and sensory disturbance (Ladewig[7]).

Most psychiatrists believe that the source of the disorder is the same in both male and female cases (Bruch[8], Crisp et al.[9], Hogan et al.[10]).

Food rejection in male cases is milder than in female cases, and there are few cases of food rejection in the true sense of the word; they eat foods in secret or have an extremely unbalanced diet (Shimosaka[1]).

In the present case too, food rejection presents itself in the form of refusing food due to gastrointestinal disorders, and it is not that the patient fear obesity. In female cases, food rejection is caused by the wish for weight reduction stemming from an aversion to physical maturity.

In male cases, however, it is impossible to interpret this symptom as aversion to the development of breasts and deposition of subcutaneous fat, as in female cases.

In female cases, self hatred as a female and a refusal to become feminized with age, accompany a strong interest in sex (Shimosaka[1], Meyer[6]).

In the present case, the patient had an above-average physical constitution, compared with his classmates or young men of his age, but self-hatred developed because his physical strength was not commensurate with his physical constitution.

He lacked masculinity in appearance, had been apathetic toward woman and sex, and was aging as a childish asexual person (Fujimoto et al.[2]).

Further, he did not show any fear of the secondary sex characteristics or an abstinent attitude toward sex.

His father died when the patient was an infant, and his grandfather has been bed-ridden over a long period of time; so there was no one in the family whom he could regard as the object of sexual identification

However, is it because the urge is absent from the beginning, or later inhibited, that the sexual urge is not observed in this patient who is in the second half of puberty?

In women, they have menstruation and ovulation physiologically, as they mature physically. That is, they become a female, physiologically, whether they are passive or negative.

In men, however, signs corresponding to menstruation and ovulation are erection of the penis and ejaculation. However, they cannot become a male simply because they have obtained these functions or showed

these signs. "In women, sex is something which is given, but in men it is something which they cannot obtain unless they seek it" (Fujimoto et al.[2]).

In the female case, this disease may be understood only from the physical side ··· rejection of maturity. In the male case, however, this disease must be grasped as an avoidance of a social role that the patient should naturally bear as a mature man.

If, however, importance is attached to this phenomenon of avoiding the social role, it could quite possibly lead to a different diagnosis.

For instance, if it is seasoned with abnormalities in the mother-child relationship, this disease would be classified as "borderline case"[11] or "Verwohnungsneurose" (Meyer[6]). If rejection of social involvement is conspicuous, it could possibly be incorporated in the simple type schizophrenia.

Viewed overall, therefore, what has been discussed above does not constitute a full explanation of the fact that the number of male cases is extremely smaller than that of female cases.

The lack of appetite in this disease is due to a positive will of the patient, and, in this sense, it is not anorexia but a rejection of food. Over-eating, eating by stealth and an unbalanced diet are also observed at one time or another; so, it should be called dysorexia.

We hope that this disease, in male cases, will be elucidated further.

## SUMMARY

We have reported one male case of anorexia nervosa.

In the present case, rejection of and aversion to sex was not markedly shown, but a fall in the social adaptability and activites was rather conspicuous.

This tendency was largely common with male cases of this disease hitherto reported.

We have pointed out that the family environment, without a father or a male, is considered to be one of the etiological factors.

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