

CLINICAL CASE REPORTS

Stigma and denial of illness in a male adolescent with Anorexia Nervosa – A case report

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ABSTRACT

Denial of illness is common in adolescents suffering from Anorexia Nervosa (AN) and represents a major barrier to early diagnosis and treatment. Males with AN may experience a “double stigma” as they face not only the burden of a mental disorder, but also one traditionally perceived as predominantly affecting females. We report the case of a 13-year-old male with restrictive-type AN, who exhibited marked illness denial, experiential avoidance, and stigma regarding his psychiatric condition, and discuss how these factors contributed to a delay in the recognition of the disorder and initiation of its treatment. Organic and psychiatric differential diagnoses are discussed. Particular attention is given to the patient’s late childhood, characterized by obesity and low self-efficacy, which may have acted as predisposing factors for the development of the disorder. Treatment focused primarily on promoting illness acceptance, resulting in progressive clinical improvement. This case highlights the need to raise awareness of AN in males to ensure timely intervention.

Keywords: anorexia nervosa; psychological denial; social stigma

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INTRODUCTION

Anorexia nervosa (AN) is a severe psychiatric disorder characterized by an intense fear of weight gain, distorted body image, and persistent behaviors aimed at restricting food intake, leading to significant weight loss and malnutrition.⁽¹⁾

AN primarily affects adolescents and young adults, and it is approximately ten times more prevalent in females, contributing to the “double stigma” experienced by males with AN (a term referring to the stigma associated with having a mental disorder combined with the stigma of suffering from a disorder perceived to be specific of the female gender).⁽²⁾ This stigma contributes to the delay in both the recognition of the illness and the initiation of treatment observed in males with AN.⁽³⁾

There are notable differences in the presentation of AN between female and male patients, particularly regarding weight-control behaviors and body image concerns. Girls often exhibit a desire for thinness whereas male adolescents may focus more on achieving a lean, muscular physique, frequently adopting a pattern of “bulking and cutting”—alternating between episodes of high-protein or caloric intake (bulking) aimed at building muscle and periods of extreme caloric restriction (cutting) to reduce body fat. Males are also more likely to engage in excessive exercise as a means of controlling weight and achieving their idealized body image.⁽⁴⁾

Denial of illness is common in AN, particularly among adolescents, and represents a significant barrier to early recognition and treatment of the disorder.⁽⁵⁾ It is a complex concept with multiple causes and can be broadly divided into non-deliberate and deliberate denial.⁽⁶⁾ Non-deliberate denial is attributable to a form of anosognosia (referring to the lack of awareness or concern regarding emaciation), limited insight (characteristic of the overvalued ideas regarding body image) and narrowed consciousness (namely indifference to hunger signals). In contrast, deliberate denial is used by patients to avoid the consequences of acknowledging the disease (namely to avoid treatment) and as to preserve a sense of self-determination.

The authors report a case in which denial of illness and the “double stigma” associated with AN in males is evident and discuss their relevance to the diagnosis and management of the disorder.

CASE REPORT

A 13-year-old male adolescent presented to the pediatric emergency room accompanied by his mother, with complaints of lightheadedness, fatigue and cold intolerance. His mother reported that over the previous three months the patient had been restricting his food intake and engaging in excessive exercise, resulting in a rapid weight loss of approximately 17 kg. She also stated that he had expressed fear of gaining weight. However, the patient lacked recognition of the seriousness of the current low body weight, minimizing the severity of his dietary restriction and excessive physical activity, while admitting that he felt better about his body image after his recent weight loss. He denied purgative behaviors. On examination, his body-mass index (BMI) was

13.7 kg/m² (weight 35.0 kg, height 161 cm, BMI-for-age percentile: 0.1). He presented with hypotension (blood pressure 88/48mmHg) and bradycardia (heart rate 46 beats per minute). Physical examination revealed muscular atrophy, dry skin and cold extremities. Laboratory tests showed hypoglycemia (45 mg/dL), hypophosphatemia (3.1 mg/dL), and hypercholesterolemia (236 mg/dL), while the complete blood count, renal function, electrolyte panel and liver enzyme were within normal range. Urinalysis was normal. Electrocardiogram and echocardiogram revealed bradycardia but no other abnormalities.

The patient was admitted to a Pediatric Inpatient Unit for clinical stabilization and refeeding. Additional investigations were conducted to exclude medical conditions that may cause weight loss, including celiac disease, Crohn’s disease and hyperthyroidism. Tissue transglutaminase antibodies and total IgA levels were within normal limits, ruling out celiac disease, and a stool calprotectin test was normal, excluding Crohn’s disease. Thyroid function tests were also normal. Tuberculosis was considered unlikely, as the patient had no history of cough, fever or night sweats, and pulmonary auscultation was clear. Type 1 diabetes was ruled out due to the presence of fasting hypoglycemia. Fatigue, loss of appetite, and weight loss may indicate malignancy; however, the absence of focal findings on physical examination or laboratory abnormalities made this possibility unlikely.

During hospitalizations, the patient was evaluated by a Child and Adolescent Psychiatrist. Potential psychiatric differential diagnoses of AN were considered, namely avoidant/restrictive food intake disorder (ARFID), body dysmorphic disorder (BDD) and major depressive disorder (MDD). ARFID is an eating disorder characterized by restricted eating that can lead to significant weight loss or nutritional deficiencies, often due to sensory sensitivities, lack of interest in food, or fear of adverse consequences such as choking.⁽⁷⁾ However, none of these features were present, while excessive exercise and body image concerns are unusual in ARFID, ruling out this diagnosis. Body dysmorphic disorder involves a preoccupation with perceived physical flaws in specific body parts rather than concerns about overall weight.⁽⁷⁾ Although the patient demonstrated a distorted perception of his body, his focus on dietary restriction and excessive exercise to achieve weight loss were more consistent with AN than with BDD. Major depressive disorder often presents with reduced appetite, weight loss and fatigue,⁽⁷⁾ which may overlap with the patient’s symptoms. However, weight loss associated with MDD occurs due to anhedonia or loss of appetite rather than fear of gaining weight or body image concerns. This patient did not report pervasive low mood, hopelessness, or other core depressive symptoms, making MDD less likely. The patient denied engaging in purgative behaviors (self-induced vomiting or the use of laxatives and diuretics), and his mother reported not observing such behaviors. However, patients with AN may conceal these behaviors. For this reason, indirect signs and findings commonly associated with purging behaviors were investigated. These include Russell’s sign (calluses or lesions on the knuckles resulting from self-induced vomiting), which was not observed, as well as laboratory findings such as metabolic alkalosis with hypochloremia and hypokalemia, which were also absent.⁽⁸⁾ A diagnosis of AN, restrictive

subtype was established, and after discharge the patient started outpatient treatment.

The patient had a history of obesity (at age 12 he weighed 60 kg; BMI 23.4 kg/m²; BMI-for-age percentile: 97) and had been bullied by his peers for this reason. Prior to the clear onset of AN he had decided to reduce his intake of highly caloric foods without displaying others symptoms of an eating disorder. This resulted in a slow and steady weight loss of 8 kg over approximately ten months. During this period, his peers complimented him on his appearance and his ability to lose weight. Subsequently, the patient intensified his food restriction, started exercising daily, developed a fear of gaining weight, and failed to acknowledge the rapid weight loss that led to his low bodyweight. This period was marked by high expressed emotion in the family, with the patient's father reacting with anger to the patient's restrictive eating behavior, while his mother attempted to pacify the father and simultaneously accommodated the restrictive eating and excessive exercise. The family later reported that they had been unaware of the possibility of a diagnosis of AN, which contributed to the delay in treatment initiation. Following psychoeducation regarding their son's mental illness, both parents came to understand and accepted the diagnosis.

Prior to the onset of the illness, the patient had been involved in minor acts of misconduct with his school peers, and his academic performance had been declining. The patient had demonstrated minor learning difficulties since his early school years, which had been partially mitigated through private tutoring and educational adaptations. However, in the months preceding the onset of AN, he had been dedicating less time to his studies, resulting in a marked deterioration in his academic performance. This led to frequent arguments with his parents, who eventually threatened to enroll him in a boarding school if his behavior and grades did not improve. The patient reported feeling frightened by this possibility, therefore deciding to improve his behavior, apply himself to his studies, and distance himself from his peers, which coincided with the intensification of the eating disorder symptoms.

After three months of non-responsive outpatient treatment, the patient was admitted to a Child and Adolescent Psychiatry Inpatient Unit. During hospitalization, he did not exhibit restrictive or purgative behaviors or excessive exercise but continued to deny his illness and symptoms. He adopted a passive stance during all psychotherapeutic activities and appeared to focus primarily on gaining weight in order to be discharged from the Unit. He later revealed that he had felt ashamed of his fear of gaining weight and of suffering from AN. He was discharged after 58 days with a weight of 44,6 kg (BMI 17,2 kg/m²; BMI-for-age percentile: 24.4) and maintained a healthy weight and remission of restrictive eating and excessive exercise in the following months. Psychoeducation regarding AN, along with the promotion of illness acceptance and healthier patterns of family communication, played a major role in the treatment plan.

DISCUSSION

We report the case of a young male adolescent suffering from AN who exhibited marked denial of illness, which

appeared to be partly motivated by stigma and shame related to his diagnosis. The delay in recognition of the disorder by those around the patient may reflect a broader societal lack of awareness of AN in males.

AN is associated with several medical complications due to severe malnutrition and its effects on multiple organ systems.⁽⁹⁾ This patient exhibited signs and symptoms commonly observed in this context, including lightheadedness, fatigue, cold intolerance, cold extremities, dry skin, hypotension, and bradycardia, and well as laboratory abnormalities such as hypoglycemia, hypophosphatemia and hypercholesterolemia.

When symptoms such as food restriction, excessive exercise, or purgative behaviors are concealed or denied by the patient, or go unnoticed by the family, it is particularly important to consider medical conditions that may cause weight loss into the differential diagnosis of AN.⁽¹⁰⁾ These include celiac disease, Crohn's disease, hyperthyroidism, type 1 diabetes, tuberculosis and malignancy.⁽¹¹⁾

Alternative psychiatric diagnoses that involve food avoidance or loss of appetite with subsequent weight loss should also be considered, namely ARFID and major depressive disorder, while the prominent preoccupation with body image also makes body dysmorphic disorder a relevant differential diagnosis of AN.⁽¹²⁾

Although this patient engaged in excessive exercise, his behavior appeared to be motivated by a desire to lose weight rather than to achieve an ideal of muscularity. He also did not engage in "bulking and cutting" as a strategy to achieve this goal, unlike other male adolescents as reported in the literature.⁽⁴⁾

The patient, who had previously been obese, experienced a period of healthy weight loss prior to the onset of illness, which was reinforced by positive comments from friends and family, who not only complimented the patient on his body image but also praised his efforts to lose weight. This may have reinforced the patient's low self-efficacy and contributed to the onset of his illness. According to Erik Eriksson's theory of psycho-social developmental, late childhood, roughly corresponding to ages 6-12, is characterized by the psychosocial crisis of "Industry versus Inferiority", and the patient, aged 13 at the onset of illness, had a history of academic difficulties that may have contributed to a sense of inferiority relative to his peers, consistent with low self-efficacy.⁽¹³⁾

Additionally, in attempting to distance himself from peers to avoid further misconduct, his peers started bullying him once more regarding his weight, which intensified his restrictive eating and exercise behaviors, precipitating the onset of AN at a time when he became socially isolated and therefore more psychologically vulnerable.

The patient's passivity during treatment may be understood in terms of experiential avoidance, which refers to an unwillingness to remain in contact with aversive experiences, such as painful feelings, thoughts, and emotions, and is believed to contribute to the maintenance of almost all emotional disorder).⁽¹⁴⁾ Shame and self-stigma related to mental illness, which the patient acknowledged at a later stage of treatment, likely contributed to this unwillingness to confront and admit to having thoughts and behaviors characteristic of AN. Additionally, high parental expressed emotion known to be associated with poor treatment

outcomes in AN, may have acted as a maintenance factor of the illness.⁽¹⁵⁾

Treatment focused particularly on promoting illness acceptance in both the patient and his family, and on reducing the stigma associated with AN. Over time, the patient progressively demonstrated acceptance of his condition and became more capable of confronting his overvalued ideas regarding weight and eating behaviors, which he admitted to having caused intense shame.

In conclusion, we present a case of a male adolescent with AN in which both denial of illness and the “double stigma” of suffering from a mental disorder that is more prevalent in females may have delayed early recognition and treatment and acted as maintenance factors of the illness. Clinicians, and school communities in particular, should be aware of the possibility of AN affecting male adolescents, in order to avoid delays in illness recognition and initiation of treatment.

AUTHORSHIP

Rui Sampaio – Conceptualization; Investigation; Writing – original draft

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