The Carter-Jenkins Center

presents

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Anorexia in Childhood: A Case Presentation

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Diagnosis, Epidemiology and Related Findings

- Eating disturbances in children are common though classical eating disorders are rare
- Anorexia nervosa can arise from the age or 7 or 8
- No epidemiological studies of anorexia nervosa have focused exclusively on children (Gowers 2004)
- "Anorexia" a misnomer in anorexia nervosa

Types of Childhood 'Anorexia'

- Feeding Disorder of Infancy and Early Childhood (DSMM IV)
- 'Infantile Anorexia Nervosa' (Chatoor 1989)
- 'Food Avoidance Emotional Disorder (Higgs et al)
- Anorexia Nervosa
- Eating Disorder NOS

DSM IV Diagnostic Criteria: Anorexia Nervosa

- Refusal to maintain body weight
- At or above a minimally normal weight for age and height (BW less than 85% ; or failure to make expected weight gain during period of growth, leading to BW less than 85% of that expected
- Intense fear of gaining weight or becoming fat, even though underweight

DSM IV Diagnostic Criteria:

- Disturbance [of body image]; undo influence of body weight or shape on self-evaluation, or denial of the seriousness of current low body weight
- In post-menarchal females, amenorrhea (absence of at least 3 consecutive cycles)
- Specification of Type: Restricting Type or Binge-Eating/Purging Type

Related Concerns of the Anorexic in AN

- Public eating
- Feeling ineffective
- Strong control needs in relation to self and environment

Related Concerns of the anorexic in AN

- Rigidity of thought, action, social spontaneity
- Perfectionism
- Passivity, lacking initiative

Related Concerns of the anorexic in AN

- Blunted emotional expression
- Detachment from relationships
- Increased impulse control problems with binge-eating/purging type (alcohol/drug, lability of mood, promiscuity, suicide attempts, borderline features

Physical Findings

- Amenorrhea
- Constipation
- Abdominal pain
- Cold intolerance
- Lethargy, decreased energy
- Hypotension

Physical Findings

- Dryness of skin
- Downy, fine hair (Lanugo)
- Slowed heart rate (Bradycardia)
- Swelling of fluid in extremities (Edema)
- Red dots on skin (Petechiae)

Physical Findings

- Yellowing of skin
- Swelling of the salivary glands
- Dental enamel erosion
- Scales, calluses on back of hand, knuckles associated with forced vomiting

Co-morbid Medical Conditions 2nd to Starvation and Purging

- Anemia
- Impaired kidney (renal) functions 2nd to dehydration and low blood salts (hypokalemia)
- Cardiovascular problems (LBP, arrhythmias)
- Dental problems
- Osteopenia and osteoporosis (porosity of bones, fracturing)

Co-morbid Psychiatric Conditions

- A symptomatic presentation with major depression and obsessive-compulsive features is possible, often related to physiology of starvation, under-nutrition
  - Differential diagnosis needs to be assessed once restoration of weight is achieved
- Narcissistic Personality Disorder
- Anxiety Disorder
- Borderline Personality Disorder
- Oppositional Defiant Disorder
- Avoidant Personality Disorder

Differential Psychiatric Diagnosis

- Alcohol and drug abuse
- Depression
- Bipolar disorder
- Schizoaffective disorder

Differential Psychiatric Diagnosis

- Feeding disorder of childhood (onset before 6 years)
- Social phobia
- OCD
- Body dysmorphic disorder

Epidemiological Findings

- Current prevalence 1 in 200 (to .8%) adolescent girls ages 15-19
- Bi-modal diagnosis peak ages of 14 and 18
- Female to male ratio: 11:1 in children and adolescent population (Gowers 2004)
- Increased frequency as of the 1960's

Epidemiological Findings

- Up to 50% of AN may develop bulimia nervosa over course of illness
- ED-NOS 5-10% post-pubertal females
- AN 3rd most common chronic illness in older female adolescents after obesity and asthma (Manzano et al 1999)

Onset

- Typically- 14-18; rare over 40
- Can begin as early as 7 y/o
- Early adolescent onset (13-18) suggests better prognosis
- May be precipitated by stressful event, narcissistic injury, separation, loss
- If treated soon after onset, child, adolescent eating disorders have a relatively good prognosis

Prognosis

- approximately 50% recover
- approximately 30% continue to have some symptoms
- 10-31 % become chronic

Prognosis

- Prognosis not generally related to degree of wt loss (Kreipe 1995)
  - rather, to:
    - length of illness
    - level of disturbance of parent/child relationship
    - co-morbid personality disorder
    - presence of vomiting

Prognosis

- mortality rate: 5.6% (Rome et al 2003)
- AN highest mortality rate of all Axis-I disorders other than substance abuse

Epidemiological Findings and Factors Specific to Children

- Severity of associated mental disturbances may be greater w/ pre-pubertal anorexics
- Smaller percentage of total body fat: children show greater emaciation with less weight loss
- Children more vulnerable to serious medical problems, including pubertal delay, growth retardation, bone mineral acquisition impairment

Epidemiological Findings and Factors Specific to Children

- No epidemiological, methodologically sound studies have been done confirming exact figures of eating disorders among children
- estimated incidence of pre-pubertal onset is between 4-8% of all cases
- 26-28% anorexic children are male compared with 4-6 % males in older populations

Epidemiological Findings and Factors Specific to Children

- Children may not readily verbalize typical fears and body image distortions
- Thus, in children underlying fantasies and dynamics must be assessed

Anorexia in the Literature

- Early Findings
- Freud
- Post-Freud
- Drive Theories and Object Relations
- Theories Focusing on Pre-oedipal dynamics

Anorexia in Childhood: a Case Presentation

- Presentation of Case of 8 year-old girl
- Discussion and Concluding remarks

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