Eating disorders are still thought of as a “female problem.” But 25% of those with anorexia and 36% of those with bulimia are males.

THE CASE
Recently, we met with J. As the teenager walked into our office for the first meeting, J’s thin, frail body and eyes surrounded by dark circles spoke volumes. The family had decided to speak with a mental health provider after J’s mother found her child’s hair in the shower drain. In that first meeting, J described being plagued by worries and a brutal exercise regimen coupled with a diet highly restrictive in both calories and variety intended to assuage a fear of being “too fat.”

In many ways, this is a run-of-the-mill description of a patient with an eating disorder. But what if we told you that J’s full name is Josh and that he is a 14-year-old boy?
You may not be surprised, but Josh’s father was. When he came in to meet with us the following week, he confided, through his tears, that he always thought that only “emotional teenage girls” had anorexia nervosa. While a number of complex factors prevented the family from seeking treatment earlier, the belief that men and boys do not suffer from eating disorders and the stigma and shame associated with that possibility are important ones.

Technology and the rise of the Internet have added new complexities. In recent years, pro–eating disorder websites have emerged as a platform through with individuals with eating disorders may share and encourage an array of eating-disordered behaviors. For example, pro-anorexia (pro-ana) forums operate on the premise that eating disorders are a “lifestyle choice” and often feature tips and tricks to promote starvation and weight loss, images of emaciated figures, and inspirational quotes (so-called “thinspiration”), as well as chat rooms that allow users to interact with one another.

Eating disorders are often thought of as a “female problem.” Even researchers, advocates, and treatment providers who are aware that these disorders affect men and boys are plagued by misinformation. For example, it has frequently been stated that 10% of individuals with eating disorders are male. As it turns out, this often-repeated statistic is highly problematic. When it was published 25 years ago, it represented the number of men and boys in treatment, not in the general population. In fact, the best available data indicate that males account for 25% of individuals with anorexia nervosa and bulimia nervosa and 36% of those with binge eating disorder. Most disturbingly, disordered eating practices may, for the first time, be increasing at a faster rate in males than in females. Unfortunately, research has not kept pace with the prevalence of eating disorders in males. In a meta-analysis of 32 prevention studies, only 4 (12.5%) included boys. Most empirical studies simply do not include males.
The treatment process for patients with eating disorders can be divided into 4 stages (for an in-depth discussion of each of these stages, see Wooldridge):

Engagement
Engagement falters for 2 reasons. First, many males fail to recognize that their behavior (weight loss, purging, binge eating, compulsive exercise, etc) is a symptom of an eating disorder. And when they do recognize this, their help-seeking behavior is often hindered by stigma and shame. All too often, friends, family, and medical providers fail to recognize that urgent medical treatment is needed. In one study, male patients with anorexia nervosa emphasized the lack of gender-appropriate information and resources for men as an impediment to seeking treatment. Moreover, research shows that males are more likely to seek treatment at an older age than their female counterparts.

Advocacy work that includes males is an essential task for both researchers and clinicians. The National Association for Males With Eating Disorders has recently been revitalized and is now a thriving organization that aims to provide leadership in the field of male eating disorders. Other
organizations, such as the National Eating Disorders Association, are increasingly acknowledging the prevalence of male patients.

There are obstacles to the alliance-building process that are specific to men and boys with eating disorders. Stigma and shame often make the alliance-building process more difficult and should be addressed early in treatment. Stigma must be named and the layers of shame and embarrassment beneath acknowledged.

Traditional constructs of masculinity make the alliance-building more difficult. Men appear to hold more negative attitudes toward mental health treatment than women. Keeping this in mind, intervention should target normative beliefs (ie, that other males don’t seek treatment), which are deeply related to the male experience of stigma and, thus, help-seeking behavior.

**Assessment and diagnosis**

Different approaches may be employed during the assessment process, ranging from an unstructured interview to a structured diagnostic interview. At present, the most commonly used formal measures of eating disorder symptomatology appear to be less applicable to males. For example, males consistently score lower than females even when their levels of psychopathology are equivalent. In addition, the measures appear to be less internally reliable among males. With these concerns in mind, a number of assessments are currently being adapted and validated for male populations.

Two diagnoses deserve special mention in male populations. First, muscle dysmorphia, a sub-classification of body dysmorphia, has gained attention in recent years. The distinguishing feature of muscle dysmorphia is the central role of muscularity-oriented, as opposed to thinness-oriented, body image concerns and behaviors. This disorder is characterized by an intense fear that one is insufficiently muscular and an excessive drive to enhance the visible appearance of muscularity. Patients with muscle dysmorphia work out and lift weights excessively, and they experience extreme anxiety in the face of missed workouts.

Second, binge eating disorder, is the most common eating disorder and affects more males than anorexia and bulimia combined. Binge eating disorder is characterized by episodes of bingeing and subsequent shame and guilt, after which the cycle repeats. All too often, health professionals address comorbid symptoms, which include diabetes, high blood pressure and cholesterol, heart disease, gallbladder disease, osteoarthritis, and gastrointestinal problems, without recognizing and treating the underlying eating disorder. Similarly, because of misinformation and stigma, men often think of binge eating as “normal guy” behavior.

While eating disorders in males exist across ages and cultures, certain populations deserve specific mention. Males who identify as gay, bisexual, and transgender are at higher risk for an eating disorder. The most widespread explanation for the increased incidence of eating disorders in the homosexual population is that gay men experience more body dissatisfaction than heterosexual men. Indeed, the lean and muscular body type, which is difficult to achieve for most, is especially idealized by gay men.

The transgender population merits further investigation as an especially high-risk category. In a recent study of college-aged youth, an eating disorder diagnosis as well as diet pill and laxative use and vomiting was most common among transgender youth compared with heterosexual and homosexual men and women.

Athletes are also at increased risk for eating disorders. Men and boys in a wide range of sports such as wrestling, boxing, racing, gymnastics, and cross country may lose weight by purging, fasting, and over-exercising. Similarly, many crew athletes go on “sweat runs,” wearing multiple layers of clothing while running in hot weather. Bodybuilders are especially likely to have muscle dysmorphia. Coaches play an important role in the effect sports have on male participants. Indeed, coaches can either promote eating disorders among athletes or be partners in treatment, promoting full recovery instead of merely a return to sports participation.

**Treatment**

A multidisciplinary and integrative treatment approach is required to fully address all the factors that contribute to the patient’s eating disorder. Unsurprisingly, better outcomes are achieved with an experienced multidisciplinary team rather than a single clinician.

Treatment teams often consist of psychologists, psychiatrists, social workers, primary care physicians, registered dieticians, and sometimes educators, clergy, and even financial advisors to facilitate expensive inpatient treatment. In a similar vein, in an effort to address the complexity of
the patient system, treatment should be integrative and include systemic, biological, cultural, psychodynamic, and spiritual domains. This emphasis on integrative treatment often stands in contrast with the emphasis on symptom-focused treatments that, while valuable, may fail to acknowledge the underlying roots of a patient’s struggles. Similarly, much has been made of the role of genetic vulnerability in patients with eating disorders. One compelling line of research suggests that the genetic vulnerability ranges from 50% to 70%. Indeed, monozygotic twins share a 50% chance of having an eating disorder if one is afflicted. At present, however, there is no consensus on what causes genetic vulnerability. Too much emphasis on genetic factors may impede the treatment process. By focusing on genetics, clinicians may overlook the role of factors such as underlying anxiety; depression; dysfunction within family systems; or psychodynamic meanings associated with food, weight, and shape, which can be addressed in treatment.

Conclusion

We are just beginning to understand how online media affects men and boys struggling with eating disorders ranging from anorexia nervosa to muscle dysmorphia. Mass media, in general, appears to have placed increasing pressure on males to pursue an unrealistic body image of thinness and/or muscularity.

THE CASE (cont’d)

In closing, let’s return to Josh. The initial stages of treatment consisted of educating Josh and his family about the fact that eating disorders don’t happen only to adolescent girls. A multidisciplinary treatment team, which included a psychiatrist, psychotherapist, and nutritionist, was engaged to address each aspect of Josh’s eating disorder. Josh’s parents were an integral component of the treatment team as well, essential to the process of helping him to normalize his eating and exercise. At the same time, Josh had a lot of work to do on his own. Although it took over a year for Josh’s weight to fully stabilize and several more years of treatment for his attitudes toward food, weight, and shape to fully normalize, Josh eventually achieved full recovery.

**Disclosures:**

Dr Wooldridge is Department Chair and Assistant Professor in the department of psychiatry at Golden Gate University in San Francisco. Dr Lemberg is a licensed psychologist in private practice in Prescott, Arizona. The authors report no conflicts concerning the subject matter of this article.

**References:**


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