Eating Disorders in Males

Orlando Zuniga

National University

Clinical Assessments II

When reading about eating disorders or body image issues, most readers think of a specific population, young females. Eating disorders can be found in just about any group of people, including males, which account for 10% of eating disorders. Most research for eating disorders is primarily focused on the female population, though recently there is more research being done on the male population due to the increase of eating disorders and its associated etiologies in males. Anorexia, bulimia, body image distortion and all of the behaviors involved in eating disorders that are common for the disorder in females apply to males, with the exception of abnormal menses, in the case of a male would be low testosterone levels.

With male eating disorders there are co-morbid disorders in addition to the normal anxiety and depression that are getting attention, like gender identity disorder and reverse anorexia, also known as the Adonis Complex. "Body image distortion is a central feature of eating disorders" (Mangweth, et al., 2003).

Historical Context

Eating disorders in males go back as far as the late 17th century with the first case by Morton in his Treatise on Consumptions where he described a young man with a nervous "consumption" which is now described as Anorexia Nervosa. The second Anorexia Nervosa case with a male was by "Robert Whytt in 1765, described a 14 year old boy that had symptoms of Anorexia Nervosa" (Reyes-Rodriguez, et al., 2011, p.266). Bramon-Bosch and her colleagues (2000) indicate eating disorders in both genders have similar findings; therefore, it would be safe to generalize research found from females to males. However, there have been differences found. Males with eating disorders have a higher tendency of being homosexuals, athletes or have been sexually abused (Bramon-Bosch et al., 2000).

Dr. Arnold Andersen, MD is one expert that frequently came up in most of the information on eating disorders for males; he is currently a medical professor of Psychiatry at the University of Iowa, College of Medicine and has also worked at the reputable John Hopkins Medical Institution.

Diagnostic Description

According to Morrison (1995) the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) has classified three primary eating disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorder Not Otherwise Specified (EDNOS). Other disorders that cause abnormal weight and diet are: Mood Disorders, Psychotic Disorders, Somatization Disorder and Simple Obesity.

Anorexia Nervosa

"Severe loss of weight (body weight reduction of 15% or more), refusal to gain weight, and a distorted body image (patients view themselves as fast, even though they may be dangerously underweight) characterize Anorexia Nervosa" (Morrison, 1995, p.388).

Criteria for Anorexia Nervosa includes: fear of weight gain, perception their body is abnormal due to weight or shape of self-evaluation, denial of significant low weight and missing three consecutive menstrual periods for females (Morrison, 1995).

There are two types of anorexics: binge-eating/purging type, this patient purges or eats in binges and the restricting type that limits oneself from a specific behavior like eating. A fear of eating in public may exist with anorexics (Morrison, 1995).

Bulimia Nervosa

Bulimia Nervosa is characterized by episodes of binge eating where large amounts of food are consumed. To avoid shape and body weight from ballooning, the individual will

compensate by exercising, vomiting, purging or using laxatives. Bulimics do not have a distorted self-image like anorexics; in fact they are commonly individuals of normal weight (Morrison, 1995).

Criteria for bulimia includes: Patient eats in binges repeatedly, patient feels that they are eating out of control; weight control is excessively repeated by inappropriate behaviors like self-induced vomiting, fasting, abusing diuretics or drugs and excessive exercise; this behavior usually occurs for three consecutive months, about twice a week (Morrison, 1995).

There are two types of bulimics: Purging type and non-purging type (Morrison, 1995).

Eating Disorder Not Otherwise Specified

There are many problems in relation to eating, appetite and weight that can be diagnosed under Eating Disorder NOS because they do not meet the criteria for Bulimia Nervosa and Anorexia Nervosa; examples include: Anorexia with normal weight, bulimia with infrequent binges, bulimia without swallowing, binge eating disorder and inappropriate weight control with normal weight (Morrison, 1995).

Etiology

The cause for eating disorders in males, according to Dr. Arnold Andersen, begins with "dieting in young boys for participation in sports, past obesity, gender identity conflicts, genetics, fear of future medical illness and sociocultural endorsement of dieting" (Fairburn & Brownell, 2002, p.189).

Biology

Anxiety, depression and other mood altering disorders have been linked back to genetics and brain chemistry, most notably the lack of Serotonin. "Evidence from family and twin studies suggest a substantial genetic susceptibility to eating disorders like Bulimia Nervosa and

Anorexia Nervosa" (Lee & Lin, 2010 p.498). In fact researchers Lee and Lin (2010) indicate that serotonin has shown regulation of appetite. "Dr.'s Lee and Lin (2010) studied human brain images through CT technology to focus on neurotransmitter function and its relation with human behavior; they found a disturbance in serotonin levels, which regulate mood and impulse control" (p.502).

This study and many others like it give health professionals the indication that biology has a role in eating disorders.

Gender Identity and Sexual Abuse

Various studies indicate that being a homosexual is a risk factor for eating disorders. It would be wise to note that body dissatisfaction and eating disorders are higher in people "sexually involved with men (heterosexual women and gay men) mostly because males emphasize visual aspects when judging on sexual attractiveness" (Ålgars, Santtila & Sandnabba, 2010, p.119). Studies performed with gay and bisexual men (Feldman & Meyer, 2007) demonstrate that "men with either a history of childhood sexual abuse, physical abuse or both were more likely to have eating disorders. Eating disorders may represent an attempt to manage the vulnerability and overwhelming emotional states associated with the abuse, using eating as a coping mechanism to address emotions" (p.418).

There is a strong correlation with anxiety, depression, child sexual abuse, substance abuse and eating disorders that are found in gay and bisexual males. In the study by Feldman and Meyer (2007), 33% of the gay and bisexual males reported a history of childhood physical abuse, and 34% reported a history of childhood sexual abuse (p.421). Giving us reason to believe child abuse can lead to eating disorders.

Athletes

Male athletes required to be in a certain weight range may be at risk for eating disorders and other weight loss behaviors, such as "restrictive eating, use of laxatives, self-induced vomiting and over exercising" (Galli et al., 2011). Sport coaches, teammates and anyone participating with sports has a contribution to the pressure a male would have to meet a specific weight or to look a certain way for the supporting fans like friends, family and spectators. Galli, Reel, Petrie, Greenleaf and Carter (2011) explain that male athletes lacking in muscularity or leanness, may experience an increase in negative mood and risk developing eating disorders or behaviors associated with this disorder.

Feelings of anxiety and sadness can create fear in males that they will become desperate to meet their goal for perfection at any cost. Males with strong self-esteem are not affected as much as those with low self-esteem (Galli et al., 2011). Other related pressures for athletes are males required to increase body size and muscle mass for a sport. These athletes have what is called "The Adonis Complex," also known as "Reverse Anorexia."

Reverse anorexia is another disorder that is linked to eating disorders. "In reverse anorexia individuals view themselves to be small and insufficiently muscular. They have a chronically distorted perception of their own size, similar to that in anorexia" (Cole, Smith, Halford &Wagstaff, 2003, p.424). Reverse anorexia is prominent within the gym and body building community, where the use of anabolic-androgenic steroids is common (Cole et al., 2003).

The end result for athletes is a cycle of rigid dieting, obsessive exercising and the use of steroids; in addition to various psychosocial issues.

Culture and Society

According to western societies, the ideal body of a male is a "muscular, V-shaped upper torso, with virtually zero fat and moderate weight; this is a result of our cultural push in the media with male celebrities and action figures for boys" (Fairburn & Brownell, 2002, p. 189). Advertising and media is progressively exposing more males with less clothing in advertisements with a focus on chest muscles, defined abdomen and well-defined arms; producing the ideal appearance of what a male should be (Fairburn & Brownell, 2002).

The idolization of the male body in western society could be a strong influence for the increase in male eating disorders (Fairburn & Brownell, 2002).

Depending on the culture within society, some cultures are affected more than others. A study done by Reyes-Rodriguez et al. (2011), found that binge eating is the most common eating disorder in Latinos and at a greater occurrence in comparison to Caucasians. This study found that different ethnic groups have various severity levels of behaviors to compensate for losing weight (Reyes-Rodriguez el at., 2011). More research needs to be conducted across various ethnic cultures to validate these findings.

Treatment

Treatment in both genders is equally the same, though with a focus on the male gender. Goals for treatment are: normalizing weight (which increases testosterone in males), adjust abnormal behaviors, treat co-morbid conditions, helping the patient think differently about body image and preparing the patient for reintegration into their healthy roles in society (Fairburn & Brownell, 2002).

Beyond individual therapy, there are a few theoretical orientations that have been found effective by many practicing health professionals. One being group therapy by way of residential

treatment centers, the other is the use of mindfulness for eating disorders and finally cognitive behavioral therapy.

Group Therapy

One of the fastest growing treatments for eating disorders is in group therapy by way of residential treatment centers. According to Dr. Arnold Andersen, a psychiatrist and specialist in males with eating disorders benefit by meeting in groups of other males with the same disorder and led by an experienced male clinician. Meeting with other males with similar concerns produces results because it allows the patients to have greater confidence and openness about their behaviors associated with eating disorders (Fairburn & Brownell, 2002).

Cognitive Behavioral Therapy

According to Dr.'s Bowers and Andersen (2007), "Cognitive-behavioral therapy (CBT) has become one of the most prominent treatment models in mental health" (p.16). CBT is one of the most recommended treatments for eating disorders mostly due to its effectiveness with eating disorders, changes in cognition distortions and schemas (Bowers & Andersen, 2007). When compared to other treatment therapies like pharmacotherapy and psychodynamic therapy, CBT has shown greater results. CBT is healthier in comparison with medication alone (Bowers & Andersen, 2007).

Research has found that there is considerable change in mood and weight was maintained even after a year of treatment ending. Patients having CBT have demonstrated significantly lower rates of relapsing and overall better results in comparison with just a nutritional counseling. As a result of the effectiveness of CBT, it is usually the first treatment offered, even before medication is introduced (Bowers & Andersen, 2007).

Mindfulness

"Mindfulness involves consciously bringing awareness to the present moment by focusing non-judgmentally on cognitions, emotions and physical sensations" (Hepworth, 2010, p.7). Many patients with eating disorders have difficulty tolerating distress and negative feelings, and use food to regulate these experiences, whether by restricting or bingeing; as a result many have the inability to distinguish between satiety signals, hunger and other physiological cues related to fullness or hunger (Hepworth, 2010).

Mindfulness therapy helps to develop emotional regulation and aid awareness of satiety cues and hunger by increasing consciousness of physical states and act "without responding in an automatic and impulsive nature to alleviate negative affect" (Hepworth, 2010). A study conducted by Australian scientist Natasha Hepworth (2010), found that in addition to individual therapy, there were reductions in unwanted behaviors as a result of mindfulness therapy, followed by reduced anxiety and self-acceptance of body image.

Summary and Discussion

Summary

Eating disorders for males have evolved over the last two-hundred years. In addition to the typical symptoms in females, which would also apply to males, like depression, anxiety and mood disorders; there are now co-morbid disorders like gender identity disorder and reverse anorexia that are almost exclusive to males.

Anorexia, bulimia and other eating disorders that fall under the diagnosis "Eating Disorders NOS," are currently under review by the DSM-V committee to update these classifications with additional symptoms. Researchers and health professionals hope to see more information in the updated DSM with added focus on males and their etiologies.

Although the cause for eating disorders has been highlighted in biology, gender identity, sexual abuse, athletes, society and cultural background; eating disordered researchers continue to find specific reasons for its etiology.

The positive effect current research has done within eating disorders is the findings of various forms for treatment. Cognitive-behavioral therapy, group therapy and mindfulness are just a few of the discussed therapies in treating eating disorders. With ongoing research, health professionals can add new treatment plans to their existing therapies.

Discussion

In reviewing many scholarly literature and peer-reviewed information, I find my own opinion with this concerning disorder has not changed, only validated. Before learning about eating disorders for males, I was aware of the general symptoms of eating disorders for the general population. Adding focus to the etiologies of males having this disorder, one will see that there is an equal risk for males and females in eating disorders. Unfortunately males feel uncomfortable in reporting their concerns related to eating disorders. In most of the research found, men feel they do not have anywhere to turn for help, mostly due to the stigma of having a "female disorder" and as a result many males will not report their concerns. Little attention is given to males in this disorder because of society's view of eating disorders being nearly limited to the female population.

The behaviors associated with eating disorders are something of a serious nature that requires further study and discussion within all communities. My hope for the future is that more male health professionals include male eating disorders in their focus of practice. As a health advocate and hopeful future Psychologist, I will be a part of this effort.

References

Ålgars, M., Santtila, P., & Sandnabba, N. K. (2010). Conflicted gender identity, body dissatisfaction, and disordered eating in adult men and women. *Sex Roles*, *63*(1-2), 118-125. doi: 10.1007/s11199-010-9758-6

Bowers, W. A., & Andersen, A. E. (2007). Cognitive-behavior therapy with eating disorders: The role of medications in treatment. *Journal of Cognitive Psychotherapy: An International Quarterly*, *21*(1), 16-27.

Bramon-Bosch, E., Troop, N., & Treasure, J. (2000). Eating disorders in males: A comparison with female patients. *European Eating Disorders Review*, *8*(4), 321-328.

Cole, J. C., Smith, R., Halford, J. C. G., & Wagstaff, G. F. (2003). A preliminary investigation into the relationship between anabolic-androgenic steroid use and the symptoms of reverse anorexia in both current and ex-users. *Psychopharmacology*, *166*(4), 424-429. doi: 10.1007/s00213-002-1352-3

Fairburn, C. G., & Brownell, K. D. (2002). *Eating disorders and obesity: A comprehensive handbook*. (2 ed.). New York, NY: The Guilford Press.

Feldman, M. B., & Meyer, I. H. (2007). Childhood abuse and eating disorders in gay and bisexual men. *International Journal of Eating Disorders*, *40*(5), 418-423. doi: 10.1002/eat.20378

Galli, N., Reel, J. J., Petrie, T., Greenleaf, C., & Carter, J. (2011). Preliminary development of the weight pressures in sport scale for male athletes. *Journal of Sport Behavior*, *34*(1), 47-68.

Hepworth, N. S. (2010). A mindful eating group as an adjunct to individual treatment for eating disorders: A pilot study. *Eating Disorders: The Journal of Treatment & Prevention*, *19*(1), 6-16. doi: 10.1080/10640266.2011.533601

Lee, Y., & Lin, P. (2010). Associations between serotonin transporter gene polymorphism and eating disorders: A meta-analytic study. *International Journal of Eating Disorders*, *43*(6), 498-504.

Mangweth, B., Hausmann, A., Walch, T., Hotter, A., Rupp, C., Biebl, W., Hudson, J., & Pope, H. (2003). Body fat perception in eating-disordered men. *International Journal of Eating Disorders*, *35*(1), 102-108. doi: 10.1002/eat.10230

Morrison, J. (1995). *DSM-IV made easy: The clinician's guide to diagnosis*. (1 ed.). New York, NY: Guilford Press.

Pritchard, M. (2008). Disordered eating in undergraduates: Does gender role orientation influence men and women the same way? *Sex Roles*, *59*(3-4), 282-289. doi: 10.1007/s11199-008-9449-8.

Reyes-Rodriguez, M.L., Sala, M., Von Holle, A., Unikel, C., Bulik, C. M., Camara-Fuentes, L., & Suarez-Torres, A. (2011). A description of disordered eating behaviors in latino males. *Journal of American College Health*, *59*(4), 266-272.