

EATING DISORDERS IN MALES

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OVERVIEW

Males may account for approx 1-5% of patients with anorexia nervosa although prior to puberty the risk increases and approx 50% of sufferers of anorexia nervosa are boys. Males account for 5-10% of patients with Bulimia Nervosa.

As with females, risk factors for the development of eating disorders in men include dieting, a pre-morbid history of obesity, homosexuality and participation in a sport that emphasises thinness. Eating disorders present in much the same way in males as in females. Differences in eating disorders in females include a later age at onset of bulimia for men, and a higher levels of obesity before the illness occurs.

INTRODUCTION

During the past 20 years, a great deal of attention has been devoted to the subject of eating disorders in women. The number of publications on anorexia nervosa and binge eating disorder has grown exponentially during this period. Studies have noted a higher than average incidence of eating disorders amongst specific sub-populations such as adolescent women, college women or adolescents of higher social and academic status or in boarding schools. Similarly, attention have been given to the correlation between images in the feminine media which impact on female body image and their relevance to the development of eating disorders in women.

Since eating disorders are far less common in males, it is hard to conduct meaningful research on them since studies are too small to draw reliable conclusions.

Cases of female anorexia have been recorded since the 11th century and the meaning of starvation was attributed to religious yearnings with starving women being described as "fasting saints". Freud recorded a case of bulimia nervosa in a female patient in the 19th century. Historically, cases of probable male starvation were described as early as the 17th and 18th centuries. However it was not until the 1980s that a research had gathered sufficient data to focus on demographic patterns, clinical features, psychiatric co-morbidity, and treatment outcomes for all sufferers of eating disorder identifying their prevalence in males.

WHICH MALES DEVELOP EATING DISORDERS?

POSSIBLE RISK FACTORS.

DIETING

Examination of the histories of women with eating disorders has shown that dieting behaviour precedes eating disorder in most individuals and is seen as a necessary condition – not a cause, of eating distress. The relationship between dieting, and a

subsequent flawed relationship with food was demonstrated by Ancel Keys in the 1940s. He conducted a controlled experiment with a population of 36 conscientious objectors – all males. It was found in this experiment that dieting changed a diete's relationship with food, changed body concept and resulted in the experience of cravings for foods high in fats and sugars that were not mitigated by normal eating.

Large national surveys in North America, Europe, Australia and Latin America show that, while levels of obesity are largely similar (almost 50% of the population is overweight, far more females diet than do males (70% compared to 25%) and this may be responsible for the protection of most males from developing eating disorders. Various researchers speculate on the factors that may influence males attitudes and behaviours concerning their weight, and which may affect the likelihood of their developing eating disorders. Certainly males appear to be more comfortable with their bodies and are less likely to believe that they are overweight and need to diet. In most developed cultures, males demonstrate dramatic gender differences in attitudes toward ideal weight and the need for dieting. This finding is important because the act of dieting itself has been noted to usually precede the onset of both anorectic and binge eating behaviours.

The reason why dieting is believed to be both a risk factor and a precipitant for eating disorders in vulnerable subjects is through a variety of psychological, cognitive and emotional mechanisms.

THE ROLE OF THE MEDIA

The media emphasise dieting and shape for females, but physical fitness and bodybuilding for males. Andersen and DiDomenica's 1992 survey of the 10 magazines most commonly read by young people revealed that the womens magazines contained more than 10 times as many advertisements and articles promoting weight loss as the men's' magazines. These investigators argues that the 10 fold difference in this gender related reinforcement of dieting behaviour is more relevant than any biological parameter to the difference in eating disorder prevalence in males and females. However researchers note the shift in socio cultural norms portraying the mesomorphic build (slim, lean and toned) as the aesthetic male ideal and note that many males snow strive to achieve these aesthetic ideals not only for expected health benefits, but also for what the ideals symbolises – control, self discipline, competence and sexual desirability. People assign overwhelmingly positive "masculine" personality traits to mesomorphic males just in the same way as women who achieve the aesthetic ideal are perceived to be more altruistic and noble, etc and possess high moral values.

PERCEPTUAL DIFFERENCE BETWEEN MALES AND FEMALES

There are however some major differences in body perception between adolescent males and females. Females are more frequently dissatisfied with their weight and more likely to perceive themselves to be overweight than are males of a relatively similar size.

In one study conducted at the university of Pennsylvania in 1993, males and females were shown a range of silhouettes and asked to choose the figure believed to be closest to how they believed they looked; and each participant was asked to choose their ideal shape.

There were marked differences. Females tended to choose silhouettes, which were larger than they are, and to choose an ideal that was unrealistically thin. Boys, on the other hand, tended to see themselves as smaller than they actually were and they chose ideal shapes that were larger.

In another survey of college students, 13% of males perceived themselves to be overweight compare to 11% who were actually overweight. A similar proportion of the females surveyed were actually overweight but 50% perceived themselves to be overweight. Not surprisingly more women go on reducing diets than do males.

We can speculate that these perceptual differences and a larger gender specific ideal weight for males may protect them from engaging in dieting behaviours. This in turn would protect them from developing an eating disorder. However it would appear that males who choose to diet endure the same risk of developing an eating problem as women.

OCCUPATIONAL HAZARDS as risk factor

Athletes who participate in sports that emphasis leanness or that match participants by weight (boxing, wrestling, crew) and competitive body builders are at risk for engaging in severe dieting and fluid restriction. In small studies in which dietary restraint and attitudes towards eating were surveyed, subsets of male high performance athletes, including distance runners, have shown disordered eating and attitudes toward body image and dieting that are comparable to those of females with eating disorders. Although the data are insufficient to assume a causal link between particular athletic pursuits and the development of eating disorders in males, some researchers have hypothesised that this subpopulation of athletes may be especially vulnerable to developing full- fledged eating disorders.

HOMOSEXUALITY as risk factor in males but not females.

Studies have been conducted within the homosexual subculture, and have also focussed on males who suffer from anorexia and bulimia. These point to a direct connection between gender identity conflict and eating disorder in males but not in females.

The homosexual male subculture places greater emphasis on body appearance and shape, and this focus on physical appearance might heighten males' vulnerability to body dissatisfaction and disordered eating. Silberstein et al. in a study of 71 homosexual and 71 heterosexual men in a university community, and Siever, in a study including 59 homosexual and 62 heterosexual male college students, reported that the homosexual males studied generally reported more body dissatisfaction on psychometric tests, and considered appearance more central to their sense of self than did the heterosexual males studied.

Yager and associates reported that 48 homosexual male college students had higher prevalence of bulimic behaviours and fear of weight gain than a heterosexual male comparison group.

Herzog et al. have reported that significantly more of the 27 male patients evaluated on an inpatient eating disorders unit reported sexual isolation,

inactivity and conflicted homosexuality than a comparison group of eating disordered females on the same unit.

Carlat and Carnago 1991 state "there is persuasive evidence that male bulimics have a higher prevalence of homosexuality than their female counterparts and that homosexuality acts as a risk factor for bulimia in males". Males with bulimia, in addition a greater prevalence of homosexuality, tend to describe lowered libido. Although diminished libido may be secondary to emaciation, females with bulimia appear to show no parallel decreases in sexual interest.

The reader is asked to bear in mind that the sample sizes may be too small for statistical significance. Overall, it may be best to simply note that a number of studies report a higher incidence of bulimia and other eating disorders in homosexual males than in heterosexual males. Conversely an elevated rate of homosexuality or gender identity issues appears to have been reported in male patients with eating disorders.

HISTORY OF OBESITY as risk factor

Compared to females with eating disorders, several small studies have shown that males with eating disorder tend to have higher levels of weight problems prior to the onset of their eating disorder. They report generally being further away from their ideal weight than females who have developed eating disorders. Carlat and Carnago's extensive review of 24 bulimia studies between 1966 and 1990 cites only 4 small studies, each with populations of between 12 and 15 male bulimics – in which data are available about the pre-morbid weights of male versus female bulimic subjects. However these findings were statistically significant in only 1 of the 4 studies, possibly due to small sample size. Edwin and Anderson's report on 76 male inpatients and outpatients referred to an Eating Disorder Treatment Service, found that the males tended to have higher maximum body weights than females. Mean maximum weight was 130% of ideal for males and 120% for females. There was significant gender difference in their perceived ideal body weights with the women identifying relatively lower weight ideals.

These findings are intriguing because we have already noted that males may have some protection from eating disorders because of their lower prevalence of dieting and more positive body image. However males who are actually obese or are in an environment which emphasises thinness may experience a negative focus on body fat and a heightened pressure to diet- that is similar to the environmental pressures experienced by females at risk for eating disorders.

ANOREXIA NERVOSA: CLINICAL CHARACTERISTICS IN MALES

Recent studies that focused on the course of eating disorders in males and the incidence of co-morbid psychiatric diagnoses demonstrate remarkable similarities between males and females with eating disorders.

According to criteria in the American Psychiatric Association's Diagnostic and Statistical manual, fourth edition, individuals with anorexia nervosa refuse to maintain a minimally normal body weight for age and height, (less than 85% expected weight), are intensely fearful of gaining weight or becoming fat, and exhibit a significant disturbance in the perception of body weight or size. An additional criterion for anorexia in post-menarchal females is amenorrhoea for at least 3 consecutive menstrual cycles. This objective criterion – amenorrhoea, is lacking in males with anorexia, which may contribute to under-recognition of anorexia in males, especially given the lower index of suspicion that many practitioners have in the differential diagnosis of emaciation in males. However most studies report that the clinical presentation of anorexia in males is quite similar to its classic presentation in females.

Purging in Males with Anorexia

Patients with anorexia nervosa are sub-classified in the DSM-IV into either restricting or binge eating/purging types. Restrictors lose weight mainly by dieting and/or exercise. Binge-purgers may have episodes of binge eating and/or may regularly self induce vomiting and abuse diuretics, laxatives or enemas. . The study by Sharp et al. of 24 males with anorexia and a matched female group concurs with earlier studies in finding that binge eating and vomiting occur commonly in approximately half of the males with anorexia compared to one third of females with anorexia. Excessive exercising was found to be more frequent and laxative abuse less frequent in the male group than in the female group, which is in agreement with other studies.

PSYCHIATRIC CO-MORBIDITY IN MALES AND FEMALES WITH ANOREXIA

The psychological profile of males with anorexia has been noted to be quite similar to that of females with anorexia, with depressive and obsessional symptoms common in both groups which may be a causal factor or a consequence of emaciation .

AGE OF ONSET

Female anorexia nervosa has peak onset in adolescent years, with the vast majority developing the disorder between the ages of 13 and 20. Relative age of onset of anorexia in males is still unclear. However some investigators have reported a tendency toward later age of onset in males; Other investigators have reported an earlier age of onset. Sterling and Segal's review article, for instance, cites a mean age of onset of 13.7 years of age for males versus 17 or 18 years for females.

Puberty occurs, on average 1 to 2 years later in males than in males. This is of interest because puberty in girls heralds the period of highest risk for anorexia. However puberty may have very different meanings for girls and boys in terms of its relationship to body image. Subcutaneous fat deposition in the breasts, buttocks, hips and other areas that contribute to the mature female contour is a dramatic feature of the pubertal process in females. Males do not experience puberty as period of gaining body fat, in fact the reverse, males tend to lose fat and gain muscle in adolescence. Studies have noted major differences between males and females in their

response to early maturation. Girls who begin puberty early experience a loss of self-esteem and a higher incidence of self abuse. Conversely, males who mature early gain self worth, social status and emotional strength.

PHYSIOLOGY OF MALES WITH ANOREXIA

Males with anorexia, like females with anorexia, experience profound physical changes that accompany severe weight loss, including stunting of growth and decrease in plasma gonadotrophins that decrease libido. Weight gain in growing males with anorexia, restores plasma leuteinising hormone and testosterone levels, and physical and emotional puberty is rekindled. Weight gain in growing females changes the physiology in similar ways and at similar thresholds of pre-morbid weight

BULIMIA NERVOSA AND BINGE EATING DISORDER IN MALES CLINICAL CHARACTERISTICS

Bulimia nervosa is a syndrome in which binge eating and inappropriate compensatory methods to prevent weight gain, occur. These may take the form of vomiting, laxative, diuretic abuse or excessive exercise.

Bulimics tend to be unduly influenced by their body weight and shape and by subjective ideas of how much it is appropriate to eat.

Binge eating Disorder exists when there are recurrent episodes of binge eating without compensatory behaviours except dieting. Binge eating is defined as eating within a discrete period of time (e.g. within a 2 hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances and feeling a sense of lack of control over eating during the episode. Binge eating episodes are associated with at least 3 of the following –

Eating more rapidly than usual

Eating until uncomfortable

Eating large amounts when not hungry

Eating alone

Feeling disgusted depressed or guilty after overeating

Obsessional thinking about food and weight

Bulimia and binge eating are far more prevalent than anorexia.

Approximately 1-3% of adolescents and young adult females have been estimated to suffer from bulimia. If bulimia is even 1 /10 as common in males as it is in females, a large number of young males are affected.

Carlat and note that most investigators believe that there is a continuum of bulimic behaviours and attitudes for which bulimia represents the pathologic endpoint and overeating is the starting point. Although the rate of binge eating among males may be nearly comparable to that of females in the community at large (Brownell et al), men appear to react with less self hatred to binge eating than do women, this may make purging less tempting Thus it is no surprise that self-induced vomiting is 4 to 5 times more prevalent among females than among males.

It may be hard to accurately identify the prevalence of binge eating in males since males may have higher thresholds for defining an eating episode as a "binge". They may less readily admit to over concern about weight and shape than females.

AGE OF ONSET OF BULIMIA IN MALES

The mean age of onset for bulimia has been reported to range between 18 and 26 for males, compared to onset of 16-18 in females. However, larger studies are needed to confirm that age of onset is later in males for bulimia.

PSYCHIATRIC CO-MORBIDITY FOR BULIMIA, MALES VS FEMALES.

Females with bulimia have a high prevalence of depression, anxiety disorder substance abuse and personality disorder; particularly cluster B personality disorders - i.e. borderline, histrionic, narcissistic, and anti-social personality disorders. A similar profile of psychiatric co-morbidity has been reported among male bulimics.

TREATMENT AND OUTCOME FOR EATING DISORDERS IN MALES

Recent reviews support the conclusion that the course of illness and treatment response for males appears to be similar to that for females.

For males and females, nutritional rehabilitation and psychotherapy, particularly cognitive behaviour therapy, are widely used to treat eating disorders. Research also demonstrates the efficacy of interpersonal therapy (IPT).

Pharmaco-therapy utilising a range of antidepressants, including Tricyclics and SSRIs (serotonergic drugs) is well known for treating bulimia. The SSRIs are being used in relatively high doses, for example 60mg per day, and have some value along with talking therapies for both sexes with eating disorder, however, there are no published studies on the efficacy of drug therapies specifically for males with anorexia or bulimia

Levin and colleagues reporting on outcomes for support-group therapy, concluded that extra effort is required by group leaders to reach out to this less prevalent, more secretive and resistant subgroup. These investigators also concluded males with eating disorders are likely to require additional social support and that a support group can have many positive effects for the men if they can it a chance.

CONCLUSION

Although anorexia and bulimia remain predominantly female illnesses, these disorders are sufficiently common so that even if only 5% of sufferers are male, hundreds of thousands of young men are affected, making it an important health problem for males. This is compounded by a tendency for eating disorders in males to go unrecognised or

undiagnosed, due to reluctance among males to seek treatment for these stereotypically female conditions. This may now be changing due to increased public information and awareness

The picture might be slightly different in the case of binge eating disorder where it is estimated that up to half of all persons who are obese, male or female, satisfy the criteria for binge eating disorder and there are no specific gender differences of note in presentation and clinical manifestations.

Important gender differences that have emerged from studies to date of the more extreme disorders, anorexia and bulimia, include a higher incidence of homosexuality, a later age at onset of illness in bulimic males, and a higher level of pre-morbid obesity in males than in females. Social pressures for thinness impact less on males; however, the growth of the fitness industry and the explosion of male lifestyle and fitness magazines giving added pressure to diet and focus on the body may be crucial. Such added attention to weight and body fat and pressure to diet might be experienced as threatening by obese males or by males in body focussed subcultures such as competitive bodybuilding and sport. More work needs to be done to identify treatment approaches, which may be of particular value to males, as well as prevention strategies, which impact on male vulnerability to developing a flawed relationship with food.