Eating Disorders in Male Patients

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The speaker has no significant financial conflicts of interest to disclose.
Objectives

- Recognize the prevalence of eating disorders in male patients is higher than previously thought.

- Appreciate the cultural and clinical complications associated with accurate diagnosis and treatment of males with eating disorders.

- Distinguish differences in presentation of symptoms of eating disorder and body image disturbance between male and female patients.
Dessert First: Conclusions

- Yes, males do have eating disorders & more than previously thought.
- Less frequent in society & presenting for treatment than females.
- There are some differences in presentation than with females.
- Cultural and clinical bias has impaired recognition & access to Tx.
- Body image disturbances tend to manifest differently in males.
- Treatment approaches & outcomes are similar as with females.
- Need for more research focused on male experience with ED & BI.
Prevalence

- Males appear to be around 5 to 10% of patients seeking treatment.

- Males are thought to be up to 25% ED samples in the community.

- Males tend to demonstrate >mortality rate
  - Later diagnosis.
  - Comorbidity

- Subclinical ED behaviors are much higher than previously thought. Restriction, purging, binge eating, exercise abuse & laxative abuse.
Prevalence: Full vs Partial Diagnosis

- Gender difference tends to be greater with full diagnosis
  - AN: 5 to 1 (female to male)
  - BN: 11 to 1 (female to male)

- Gender difference tends to be lesser with partial diagnosis
  - Restriction based NOS: 1.5 to 1 (female to male)
  - Binge/Purge based NOS: 2 to 1 (female to male)
Gender based ED tendencies

- Males tend to be LESS likely than females:
  - Vomiting
  - Restriction
  - Body checking
  - Interpret eating behavior as “out of control”

- Males tend to be MORE likely than females:
  - Overeat

- Males and females tend to similarly:
  - Exercise Excessively
  - Abuse laxatives (some studies show males somewhat less)
Trends in Treatment Seeking Males

- A quarter to a third of adolescents with ARFID tend to be male.

- Of males participating in INPATIENT treatment:
  - Restriction based diagnosis (AN): 30% to 50%
  - Binge/Purge based diagnosis (BN): 20% to 40%
  - Binge eating based diagnosis (BED): 05% to 20%

- Males participating in OUTPATIENT treatment:
  - Increased likelihood of BED.
  - Limited data make conclusions difficult to determine
Problems with Historical Perspective

- Eating disorders have been thought to be “female” disorders
- Males with ED have tended to be considered atypical
- Males with ED have historically been underrepresented
  - Presentation
  - Treatment
  - Research
Eating disorders have historically been thought of as female only.

Research & treatment tend to focus towards female patients.

This strengthened the image that there are no males with ED.

Males who have ED symptoms become stigmatized or “atypical”.

Due to stigmatization, males more likely to hide or ignore symptoms.

Males who do present for treatment more likely for misdiagnosis.

Resulting in less focus on research that includes or targets males

Resulting in less focus on treatment approaches for males with ED.
Presentation in Treatment

- Males vs females: There are more similarities than differences.
- Males are less likely to seek treatment overall
  - Individual: Stigma may reduce symptom reporting
  - Clinician: Poorly educated clinicians may miss important cues.
  - Families: Less likely to see behavior as problematic
  - Society: Cultural views that it is not “manly” to exhibit ED symptoms
- Less worry about eating, making it easier to misinterpret symptoms.
- BN: Symptoms in females tend to onset in teens, then decline. A similar onset time in males (teens), then tends to increase in the 20’s.
Males present for first treatment at a later chronological age.

Males present at a later stage of the disease process than females.

Delayed presentation considered to be a factor in higher symptom severity at first presentation.

Males with ED tend to have higher rates of comorbid psychiatric and substance abuse disorders.

Males tend to have more history being overweight before ED.

Males tend to have a greater history of weight related teasing and bullying at an early age.
Medical Considerations

- Similar medical considerations as with females.
- Low testosterone
- Low levels of Vitamin D
- Bone density loss may be greater for males.
- SSRI’s have been proven to be helpful for symptoms of BDD.
- Cosmetic surgery and dermatologic interventions are frequent medical entry points (both ED & BDD).
Subgroup: Male Athletes

- Less risk for male athletes than for female athletes
- Greater risk for male athletes than males in the general population
- Greater degree of eating pathology in male athletes
- Sports emphasizing leanness & power ratios (climbing)
- Weight class sports (wrestling)
- Appearance sports (bodybuilding - steroid use)
- Strength sports (powerlifting - steroid use)
Subgroup: Homosexual Males

- Increased risk for body image disturbance.
- Increased risk for eating disorder behavior.
- No tendency for increased risk in homosexual women.
- Increased risk for single gay men versus those in relationships.
- Homophobic assumptions related to ED symptoms and men.
Male Body Image

- Females: Tend to focus on thinness & reduced weight.
- Males: Tend to focus on leanness & muscularity (≤BF / ≥LBW).
- A quarter of men tend to perceive themselves as underweight.
- Sexual objectification contributes to obsession with muscularity.
- More than 75% of male teens tend to desire more muscle definition.
- Similar number of males want to increase weight as to decrease it.
- Late maturing males tend to have a greater degree of body dissatisfaction.
- Disordered eating increases with efforts of gaining muscle, eating beyond full feeling, and combined with intensive strength training.
Body Image Differential Diagnosis

- **Body Dysmorphic Disorder (BDD)**
  - Classified within the Obsessive Compulsive & Related Disorder category.

- **Muscle Dysmorphia (Bigorexia)**
  - Specifier of BDD in DSM V, but not recognized in ICD 11 (evidence).
  - Primary body image disturbance of males with ED (separate ED dx?)
  - Preoccupation with muscularity or leanness.
  - Obsession with workouts - can interrupt social functioning.
  - Rigidity in diet and reliance on supplementation or steroid abuse.
Body Dysmorphic Disorder  F45.22

- DSM-5 from the American Psychiatric Association
- Preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others.
- At some point during the course of the disorder, the individual has performed repetitive behaviors (e.g. Mirror checking, excessive grooming, skin picking, reassurance seeking) or mental acts (e.g. comparing his or her appearance with that of others) in response to the appearance concerns.
The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The appearance preoccupation is not better explained by concerns with body fat or weight in an individual whose symptoms meet the diagnostic criteria for an eating disorder.

Specify if:

With muscle dysmorphia: The individual is preoccupied with the idea that his or her body build is too small or insufficiently muscular. This specifier is used even if the individual is preoccupied with other body areas, which is often the case.
Body Dysmorphic Disorder (page 3)

- Specify if: Indicate degree of insight regarding body dysmorphic disorder beliefs (e.g. “I look ugly” or “I look deformed”)
  - With good or fair insight: The individual recognizes that the body dysmorphic disorder beliefs are definitely or probably not true or that they may or may not be true.
  - With poor insight: The individual thinks that the body dysmorphic disorder beliefs are definitely or probably true.
  - With absent insight/delusional beliefs: The individual is completely convinced that the body dysmorphic disorder beliefs are true.

- DSM-5, American Psychiatric Association, 2013
Muscle Dysmorphia

- Most likely in males aged 20 to 40.
- Size perseveration of >3 to 5 hours per day
- Frequent body checking (up to a dozen + times per day).
- No tendencies associated with height or sexual orientation.
- No significant preoccupation with weight or weighing behavior.
- Tendency towards camouflage or hiding in clothing (controversial)
- Body dissatisfaction: Fat phobic vs insufficiently lean / muscular
- Some reports of chronic difficulty with relationships (esp. intimate).
- More likely to use steroids
BDD and Eating Disorders

- Common comorbid disorders.
- Patients with both are more likely to seek treatment.
- Comorbidity intensifies symptoms of each disorder.
- Suicide risk is compounded with this comorbidity.
- Visual processing of appearance perception is distorted with both diagnoses, thus complicating the treatment planning.
- Muscle Dysmorphia is more complex with comorbidity.
- The Chicken or the Egg – it can be difficult to determine which diagnosis is primary. More ED trained clinicians means ED focus more likely.
Supplements & Steroids

- High consumption of protein, glutamine, creatine, branched chain amino acids, carnitine, and related supplements.
- High motivation and regimentation of strength training activities.
- When nutrition, supplements and ST are not enough > Steroid risk.
  - Rapid development of muscle mass when combined with ST
  - Common result/complication of Muscle Dysmorphia
  - Due to stigma, steroid abuse is frequently & vociferously denied
  - Greater risk for steroid abuse due to the connection with Excessive Exercise, Muscle Dysmorphia & Affect Regulation.
Exercise: Excessive vs. Compulsive

- What makes exercise excessive?
  - Activity that is not supported by energy and rest patterns (pyramid).
  - Not specifically designed to achieve an appropriate physiological goal.
  - Belief in the “more is better” exercise mentality (dietary: Less = More).
  - Psychoeducation & behavioral structure are the primary interventions.

- What makes exercise compulsive?
  - Habitual demands that dominate all reasonable expectations.
  - Permission (eat, rest or recreate) dependent on completion of exercise.
  - Primary function is to “purge” or eliminate the obsessive expectation.
  - CBT & OCD based strategies are the primary interventions.
Treatment Planning

- Most studies focus on treating females
- Same treatment models tend to work for males (as far as we know)
  - Family based treatment for AN minors
  - CBT
  - Trauma informed treatment
  - Multidisciplinary treatment team
  - Individualized and focused treatment planning
  - Focus more on impaired functioning vs emotional distress.
- Treatment outcomes appear to be similar as with females.
Hints to Keep in Mind

- Address the client’s views on gender roles
- Reevaluate the concept of masculinity
  - MD = tends to be thought of as movement towards more masculine
  - AN = tends to be thought of as movement towards more feminine
- Be aware of the tendency to hide offensive or embarrassing beliefs
  - Sexism
  - Homophobia
  - Projection of personal fears
  - Hidden inadequacy
Hints to Keep in Mind (2)

- Try to determine if ED or BDD is the primary driver
  - Detailing symptom patterns for body image disturbance.
  - The primary drivers for ED behaviors vs compulsive body image drives.
- Pay attention to suicide risk, especially with unique risk factors
  - BDD
  - Steroid Cycling
  - Comorbid psychiatric and substance abuse
    - Hopelessness
    - Agitation
    - Alcohol abuse
Clinical Case Examples

- **Competitive Climber**
  - 19 year old male / Restriction / Drive to optimize the strength-to-weight ratio drifts into restrictive behaviors, triggering & solidifying ED beliefs.
  - Psychoeducation / CBT / Sports Nutrition

- **High School Wrestler**
  - 16 year old male / Restriction / Highly driven quest for a competitive edge by dropping weight class failed with reduced strength.
  - Higher level of care to interrupt entrenched behavioral patterns.
Clinical Case Examples (2)

- **Recreational Body Builder**
  - 24 year old male / BDD / Restriction & Purging / Single / Gay
  - Poor BDD insight, dropped out of treatment

- **“Just a regular guy who missed my chances”**
  - 42 year old male / BED / Obesity / Single / Works from home, describes food as his only “joy” and in treatment due to >cardiovascular risk.
  - Multidisciplinary outpatient team treatment
Challenging Questions

- Is it an option to add males to female only treatment programming?
  - Inpatient eating disorder programs vs general psychiatric units
  - Outpatient group treatment: Male only vs mixed gender groups
- Should there be a separate diagnosis for Muscle Dysmorphia?
- Because of the common comorbidity of ED & BDD, should ED clinicians receive more training in assessing and treating BDD?
- Considerations for Trans patients in group therapy?
  - Upcoming ECHO ... STAY TUNED!
Dessert Finally: Conclusions

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Jaworski, Panczyk, Sliwczynski, Brzozowska, Janaszek, Malkowski & Gotlib, American Journal of Men’s Health, 7/2019


