# Keeping pace with the growing problem of male eating disorders

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**Men can and do develop eating disorders, and the prevalence of extreme dieting and purging has increased faster among men than women. As well as anorexia nervosa, bulimia nervosa and binge-eating disorder, men are affected by muscle dysmorphia and other muscularity-orientated eating issues.**



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Despite a public perception to the contrary, men can and do develop eating disorders. Studies have shown that males may account for approximately 25% of cases of anorexia nervosa and bulimia nervosa and 33% of binge-eating disorders (US data), and 25% of early-onset eating disorders in pre-adolescent children (Australian data).[1,2]

Alarmingly, these figures are set to rise. Data from a cross-sectional survey of 3000 adults in Australia conducted in 1998 and again in 2008 showed that the prevalence of extreme dieting and purging increased faster among the men than the women.[3] The prevalence of strict dieting or fasting, purging and binging more than doubled among men in Australia between 1995 and 2005.[4] Stated plainly, the problem of eating disorders in males is going to get worse before it gets better.

## The spectrum of male body image concerns

Complicating matters even further is that current prevalence figures might tell only half of the story. Most men do not desire the thin and skinny body coveted by most women. A study of undergraduates in the USA has shown that the ideal male body is similar to that of most competitive swimmers: broad-shouldered with a muscular chest, well-developed arms, big biceps, a V-shaped torso and a set of six-pack abs.[5]

If we accept that eating disorders such as anorexia nervosa are often the result of a preoccupation with, and overvaluation of, thinness, how should we address those men who are preoccupied with, and overvalue, muscularity?[6] If the abuse of laxatives and diuretics are examples of eating disorder behaviours motivated by the desire to be thin, how should we conceptualise the abuse of anabolic steroids?[7] Men's dissatisfaction with their muscles may explain why the proportion of needle-exchange users who reported that their last injection was steroids increased from 2% nationally in 2007 to 7% in 2012, and even more

**TABLE. EATING DISORDERS: WARNING SIGNS AND RISK FACTORS FOR MEN**

| Eating disorder | Particular warning signs and risk factors for men |
|---|---|
| Anorexia nervosa | Compulsive exercise or overexercise, participation in 'high-risk' (i.e. high caloric demand) sports including marathon running or long-distance cycling, increased conformity to traditional feminine gender roles, childhood history of overweight/obesity, homosexuality, low testosterone, past history of eating disorder or muscle dysmorphia |
| Bulimia nervosa | Similar for anorexia nervosa |
| Muscle dysmorphia | Preoccupation with becoming more lean and muscular, continuing to work-out despite serious pain or acute injuries, participation in competitive bodybuilding, experiencing of substantial shame, guilt or depression if unable to train or diet broken, anabolic steroid use, muscle-building and fat-burning supplement use, homosexuality, increased conformity to traditional masculine gender roles, childhood history of bullying especially in relation to size and/or appearance, past history of anorexia nervosa or any other eating disorder |

strikingly, from 2% to 12% in New South Wales over this time period.[8]

Muscle dysmorphia, sometimes referred to as 'bigorexia' or 'reverse anorexia', was formerly positioned as a subtype of body dysmorphic disorder and is currently subsumed under the diagnostic category of obsessional disorders in the *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders*, 5th edition). The primary diagnostic criterion for the condition is a preoccupation with becoming more lean and muscular.[9] Other criteria include avoiding bodily exposure or enduring body exposure only under intense duress, steroid use and significant impairment in social, occupational or interpersonal functioning.[9] The condition has been associated with lower quality of life, steroid use and dependence, and suicide attempts.[10-12]

Debate over the diagnostic placement of muscle dysmorphia is ongoing.[13-15] Preliminary evidence suggests that therapies used for treating eating disorders may also be effective for treating muscle dysmorphia.[16] Population-prevalence data for muscle dysmorphia is unavailable.

## Early detection of eating disorder symptoms

It is imperative to detect eating disorders in men early, and GPs play a key role in recognising early symptoms. More similarities than differences exist between men and women with anorexia nervosa, bulimia nervosa or binge-eating disorder. Notable warning signs of and risk factors for eating disorders in men are listed in the Table.

### Anorexia nervosa and bulimia nervosa

Patients with anorexia nervosa achieve and maintain low bodyweight by dietary restriction whereas those with bulimia nervosa aim for the same result by recurrent cycles of binging and purging. Binging occurs when a person eats large amounts of food and experiences a loss of control over eating; purging occurs when a person induces vomiting or takes laxatives or diuretics.

For men with anorexia nervosa, warning signs and risk factors may include significant reductions in bodyweight, body dissatisfaction, low testosterone levels, homosexuality, a history of sexual abuse, a family or past history of anorexia nervosa, employment in high-risk jobs that have a focus on aesthetic appearance (e.g. modelling and acting), participation in high-risk sports or hobbies that focus on aesthetics or have a weight-related component (e.g. dancing, figure skating, bodybuilding, boxing and weightlifting) and participation in sports that involve long hours of physical exertion with heavy caloric demands (e.g. marathon running or other long-distance sports).[17-19]

Men with anorexia nervosa exhibit more compulsive exercise behaviour than women with the condition, and are more likely to depend on exercise to regulate their emotions, using it to rid themselves of negative feelings and increase their positive feelings.[20] Men with anorexia nervosa may exhibit greater conformity to traditional feminine gender roles.[21,22]

The warning signs of and risk factors for bulimia nervosa in men are similar to those of anorexia nervosa.

### Muscle dysmorphia

Men with muscle dysmorphia or other muscularity-orientated eating issues are difficult to spot because they may have an outwardly healthy appearance. Warning signs and risk factors include a preoccupation with becoming more muscular, continuing to work-out despite serious pain or acute injuries, participation in competitive bodybuilding, excessive mirror-checking, experiencing of substantial shame, guilt or depression if unable to train or diet broken, anabolic steroid use or dependence, homosexuality, a childhood history of bullying especially in relation to size and/or appearance, and a past history of anorexia nervosa or any other eating disorder.[14,23]

Moreover, men with muscle dysmorphia may exhibit greater conformity to traditional masculine gender roles.[21,22]

## The GP's role in managing eating disorders in men

GPs have a particularly important role in the recognition and treatment of eating disorders in men, and GPs working with male

patients suspected of having an eating disorder or muscle dysmorphia should be encouraged to be proactive and act swiftly.

Men with eating disorders are often stigmatised, being perceived as less masculine for having a disorder widely-considered to be 'female'.[24,25] Further, men who think that they have an eating disorder – that is, men who have not yet sought a diagnosis – report more self-stigma of seeking treatment, punishing themselves more than women do for needing to reach out for help.[26] Because eating disorders are perceived as a women's illness, men who are resistant to stigma may nevertheless fail to recognise eating disorder symptoms, resulting in delayed seeking of treatment and a more entrenched illness.[25]

Men with muscle dysmorphia tend to be more masculine on average, and masculinity is associated with less willingness to seek professional help.[27] Moreover, young men are particularly infrequent visitors to GPs, meaning fewer opportunistic encounters in which to identify eating disorder symptoms.[28] Additionally, even when seeking help, men with eating disorders are more likely to receive inaccurate diagnoses and face the frank dismissal of their symptoms simply on the basis of their sex.[29]

### Recommendations for managing men with eating disorders

Key recommendations for GPs who want to improve their ability to detect and help men with eating disorders are listed below.

- Dismantle any biased thoughts they themselves may have that eating disorders are a 'female' problem.
- Be intimately familiar with the diagnostic criteria, symptoms and warning signs of eating disorders in men.
- Foster an environment that encourages the disclosure of information surrounding eating disorders and body image:
  - look out for body image concerns in men in at-risk populations. Because of the pervasive stigma and shame faced by men with eating disorders, men presenting with eating disorders often report parallel concerns such as depression or anxiety, rather than explicitly reporting body image concerns
  - use masculinised language when screening for body image concerns to offset the self-perceived stigma of lesser masculinity among those with eating disorders. Words like 'physique' and 'definition' are recommended instead of traditional screening phrases such as 'body image'
  - reassure the patient that any disclosures will be met with compassion and without judgement
  - ensure confidentiality. This may be particularly helpful considering the legalities of some muscle-enhancing agents used in the pursuit of greater muscularity.
- When indicated, cite prevalence statistics for men with eating disorders and explicitly dispel the idea that body image or eating are issues that only women are concerned about.
- Deviation from the use of standardised questionnaires for assessing eating disorders and body dissatisfaction may be warranted, given that male body image is typically most orientated towards the upper body and abdominal regions, in contrast to women's concentration on buttocks, hips and thighs. The Eating Disorder Assessment for Men (EDAM) and the Male Body Attitudes Scale (MBAS) are useful questionnaires for assessing male eating disorders and body dissatisfaction respectively.[30,31]
- Perhaps most crucially, when patients disclose any concerns around body image or their eating practices, refer them quickly to a specialist service.

## Conclusion

GPs are likely to see an ever-increasing number of men with a spectrum of eating disorders including muscle dysmorphia. Because of the stigma associated with having a 'female' problem, these men are often reluctant to disclose the full nature of their symptoms. This poses a unique challenge to ensure that an appropriate diagnosis is made and that the patient is referred to a clinical psychologist or psychiatrist with a special expertise in treating men with an eating disorder. MT

## References

A list of references is included in the website version (www.medicinetoday.com.au) and the iPad app version of this article.

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