Eating Disorders and Men

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The Emily Program

Men and Eating Disorders

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Chief Medical Director

emilyprogram.com June 2010

Thanks

- Roberto Olivardia, PhD
- Alison Darcy, PhD
- Jerel Calzo, PhD
- Arnold Anderson, MD
- Doug Bunnell, PhD
- Leigh Cohn

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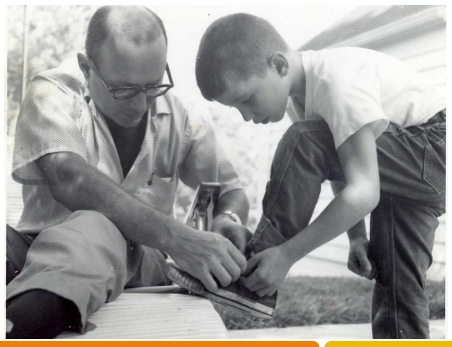

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Who Am I Anyway

- Professional
- Personal
- Why does this matter

Arnie Anderson, MD

- Serious and Potentially Life-Threatening
- Frequently overlooked or trivialized
- Raise intellectually intriguing scientific, sociocultural, and historical questions
- Present clinicians with challenges in identification and treatment
- Illustrate trends in social and medical bias over centuries
- Appear to be increasing in onset and prevalence

Personal Reflections

- Joy of Sharing
- Positive impact on my life
- How is my experience the same
- How is it different
- Does Gender Matter

Four Steps

- Getting fed- core question
- Finding a safe community
- Getting Good Treatment
- Letting go of secrets

Beginning

- Obsessions about size and shape in teens
- Triggers
- Behaviors by age 16- restrict/run
- Cross Country since 13- normal growth curve till 16
- Restrict food choice
- Constant weighing
- Constant obsessing

What did it feel like

- Normal
- Cut off
- Liked self/hated body
- No insight or understanding at all
- Not miserable as far as knew it
- Little emotional experience

College

- Schoolwork
- Weight
- Got awards
- Gym and weighing
- Panic attacks/orthostasis

College

- Treating anxiety with Valium and EtOH
- Weight stabilized- treating comorbid issue
- Thoughts still crazy
- Decided to go to med school

Med School

- Disaster
- Depression
- Isolation, eating less
- Quit-hard, no support, no understanding of process, no ability to explain
- First decision

What did I know

- Nothing
- Invisibility as man to all
- BMI 17 and on no one's radar
- All I knew I was off track comple

Lucky Break

- Hopkins Spring Fair
- Wizard of Oz pre VCR
- Mayor of Munchkin Land
- Met Lisa


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Refeeding

- Lisa as house cook
- She loved me
- She insisted I eat
- I ate
- The greatest fortune in the world- I couldn't feed myself but she could, even though she didn't know I was ill
- Recovery begins

Refed

- Gained to BMI 21 in 3 years
- Felt able to be more of me
- Went back to med school and graduated
- Finally felt able to grow past our community of two
- As refeeding ends, community begins

Being a Man

- Do men feed women the way Lisa fed me?
- Do men love women the way Lisa loved me?
- Do women care less about how men look?
- Do women care more about their partner's health?
- Questions without answers

Community

- New Alchemy Institute on Cape Cod
- Growing food
- Eating with others
- Food as health

Shame

- Living in close quarters
- Being naked
- Girls in my bathroom
- Need to develop tolerance for exposure

Shame

- Dominant emotion/sensation
- Focus of the ED
- Focus of Therapy
- Focus of Life

Connection

- A male privilege or curse
- Growing up in a pre-feminist world
- Believed in right and wrong and I had to be right
- Thought connection and community were for girls
- Listening was cowardice
- Solution to the problem of shame

Community

- All were women based, all my healing was done my women
- Finally learned I had an ED- 10 years later
- I still live in a world of women and community

Residency and Therapy

- Move to Boston
- Learning about Blind Spots
- Started Gestalt therapy, continued in Cleveland
- Highly experiential and group oriented
- Continued till I was age 40
- Worked on shame and connection in detail- all the things I had learned became more real for me

Another Lucky Break

- Met Lucene Wisniewski, PhD
- Started CCED together (Now The Emily Program)
- Forgot to tell her about my ED (oops)
- After 2 years, shared the story
- Became the professional I wanted to be
- Started letting go of secrets

Male Professional in Recovery

- Dominated my internal experience
- Secret influenced everything
- Why was I doing this work?
- Why was the secret important?
- Secrets were easy
- No one EVER asked me

Male Privilege

- Easy to keep secrets
- To give up secret meant giving up some privilege
- Stopped being a benevolent male leader and became one of the girls
- Unfortunately also felt like a hypocrite
- Denying who I was at high cost to relationships

Letting go of secrets

- Parents Group
- Parents and patients needed to know me better
- Why was this man working with teenage girls?
- And I started to ask, who am I in the larger world of ED

Impact on Relationships with Women Professionally

- Helpful to know
- Greater intimacy
- Less power dynamic
- Greater curiosity
- Safer

Impact on Relationships with Men Professionally

- The more I told people about ED, the better my relationships with men became
- Intimacy continues to grow
- Happier with my male friends and connections now than ever before

Is my experience like a Woman's in the field?

- Probably easier to be out
- Less judged
- Less concern about if it is okay for me to be in the field
- No one ever asks me about my history

What is Recovery

- A question I had to answer if I was to be a professional in recovery
- This is the question that everyone does ask- What does it mean to be recovered?

Feeling Recovered

- Fully Refed
- No behaviors
- Good enough Body Image
- Full perceived body experience
- Sense of integration and connection
- Sense of flexibility in thoughts and body

How to Share a History of an ED as a Professional

- If I reveal for me, because it is distracting or feels dishonest if I don't, I always say it is for me
- If I reveal to join with a client, or because of a need I perceive, I will say this
- Always ask for impact
- The session may be about the client's reaction, it is never about me
- Try to tell the WHOLE truth

Self- Involving Self Disclosure

- From DBT
- Purpose of my story when I share
- What it isn't
- What it is
- You don't have to be like me
- Treatment exists so you DON'T have to be like me

Sharing as a Man

- Supports Biological Theories
- Speaking to male patients
- Speaking to parents
- How is my experience different?
- Rarely referred to by others in workplace
- Male issue dominates perception- man as doctor, man as leader

Personal, Professional and Science together

- Science
- Experience matters, but as a professional I support science as the foundation of treatment
- No one should be treated except by someone who has been trained in the best treatments

The Best Care

- Refeed First and stop behaviors
- Find a community that supports being healthy
- Get good treatment that:
  - Patterns a life into one where the Eating Disorder is not central
  - Works on Feelings and Body Image
  - Works on thoughts
- Let go of Secrets

But what was happening to men in the world of Eating Disorders and Science?

In the Beginning…

- Adam and Eve
- Roman Vomitoriums
- Jesus and Fasting
- Anchorites
- Holy Anorexia
- Gender and Restriction are entwined throughout our cultural history

What Does it mean if Men have ED?

- Diagnosis is organized around women
- Criteria based in women
- Studies done with women
- Screening tools normed to women
- Professional field populated by women
- Treatment normed to women

What has Focus on Women Meant for Men?

- Gender Roles
- Sexuality
- Objectification
- Sociocultural Causation
- Notions of Biology and Genetics and how they exist in relation to Sociocultural Environment

What do we know about our own history?

- Role of psychoanalytic theory of AN as fear of Oral Impregnation or a Post-Partum illness
- Cultural changes in the 60's to 80's that affected accepted social gender roles and the impact on new understandings of Eating Disorders
- Focus on Amenorrhea as primary marker of Anorexia by Physicians through the 80's
- Role of Hilde Bruch

Current Sample Screening Questions

- I think my thighs are too big
- I think my buttocks are too large
- I have troubles expressing my emotions to others
- I am preoccupied with the desire to be thinner

What does it mean for men with AN in the 1970's?

- To experience triggers
- To read Hilde Bruch and feel left out
- To read feminist theory and feel left out
- To feel invisible
- To not get treatment
- To not know that you are ill

Early Writings on ED

- Richard Morton, 1689- Reported AN in two patients, one male and one female- describes illness as almost exactly the same in both children (age 16 and 18)- Treatise of Consumptions- 1689
- 1770's- Timothy Dwight- student of Noah Webster- identified as AN
- 1790- Robert Wilan- described male patient with AN
- William Gull- 1868- Address to British Medical Association- described AN in both women and men- paper published 1873- focus primarily on women, but acknowledges men

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Historical Literature

- 1873- Term Hysterical Anorexia- De l'Anorexie Hysterique- from Ernest-Charles Lasesegue
- Kafka- The Hunger Artist
- Men start to disappear from the conversation
- Then the entire conversation starts to disappear

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Pub Med Anorexia Nervosa 1900 to Present

PubMed Search "Anorexia Nervosa" in All Fields

Year Range	# of Results	# of Male Results
1900-1909	0	0
1910-1919	1	0
1920-1929	0	0
1930-1939	1	0
1940-1949	21	0
1950-1959	111	0
1960-1969	503	129
1970-1979	1158	409
1980-1989	2366	719
1990-1999	2718	710
2000-2009	3781	961
2010-present	1521	302
TOTAL	**12181**	**3230**

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What Happened

- Psychoanalytic thought dominated psychology and focus was on "hysteria" and "neurosis"
- 1920- 1940- AN thought to be a variant on a medical condition- usually an endocrine disorder (Hepworth, 1999)
- 1940's- New psychoanalytic interpretations of AN emerged- focused almost entirely on sexual factors
- 1960's- Beginning of both scientific interest and expansion of ED interest
- 1960's- Arthur Crisp- empirical studies that included men

Hilde Bruch

- Delusional Body Image Proportions
- Disturbance in understanding of nutritional needs
- Body and brain communicate, but this is learned and parents can sabotage the learning process
- Boys are reinforced to eat by comparison to father, girls are ignored
- Eating as a socially learned phenomena

Hilde Bruch-Golden Cage

- Psycho-social illness
- Almost never affect boys
- Think of themselves as attractive
- Impacted by Social Class
- AN seen as desirable to the sufferer

Hilde Bruch 1978

- "During the 1950's it was acceptable to be a compliant, nice, sweet girl. If she were bright enough, and from the upper class, she was supposed to go to college and meet a nice Harvard man and settle down. Now this same girl goes to college to write a PhD thesis and get a job in Washington. Girls with conforming personalities feel obliged to do something that demands a a great deal of independence in order to be recognized. When they get stuck, the only independence they feel they have to control is their bodies…I am convinced the illness goes together with the woman's movement, because this is what the girls want: to show they are something special."
- Interview- People Magazine

What is wrapped in this?

- No men
- Movement from notions of "hysteria" to psychosocial causes (DSM-II)
- Blaming of family and culture
- This is foundational to our historical and cultural understanding of AN, and often for all ED

Early Diagnosis

- Tried to make sense of all this
- Russell Criteria- 1970- amenorrhea in women, loss of sexual appetite in men
- Feighner Criteria from 1972- amenorrhea, lanugo, bradycardia, bulimia, vomitting

DSM III

- Intense fear of becoming obese
- Disturbance of Body Image- claim to feel fat
- Wt loss of 25% or 25% of projected for adolescents
- Refusal to maintain minimal body weight for weight/age

DSM III-R

- Refusal to maintain body weight over minimal normal leading to body weight 15% below expected or failure to make expected weight gain leading to body weight at least 15% below expected
- Intense fear of fat
- Disturbance of body image
- Primary or secondary amenorrhea in women

Bulimia Nervosa and BED

- Defined by Gerald Russell in 1979
- Focus on BED in 1990's
- Studies show up to 40% of sufferers are men
- Men again move toward the center of the conversation as the concept of what an ED actually is becomes relevant

Sociocultural Changes

- Interest in males with ED tracks social changes
- Changes in social body norms
- 1980's- Emergence of Gay culture- Men with ED thought to be gay, beginning of lean and mean male images
- 1990's- Emergence of Hypermuscularity- Men with ED thought to be in gyms, Overtaking of male image as cut and chiseled, widespread use of supplements
- Now- Wonders about genetics, promotion of illness, diversity of diagnosis

Now-Men with ED

- Significant rates of disorders in boys and men
- Major gaps in knowledge and research
- Research about ED is still primarily about women with ED- 25% of studies include men and is unchanged since the 60's

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Epidemiology of ED and Men

- Roberto Olivardia, PhD

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Do eating disorders affect males?

- Anorexia (.3%), Bulimia (.5%), and binge eating disorder (2.0%): Lifetime prevalence
- 10-30%: People with bulimia are male
- 10-30%: People with anorexia are male
- 40%: People with binge eating disorder are male
- 5%-20% of male university students at risk
- 1 in 4 people with eating disorders are male, but only 1 in 10 patients are male
- Anywhere from 4-6 million males
- Age of onset: 14-16

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Epidemiology in Men

National Comorbidity Survey Replication, (2007)

– 9000 households

- Lifetime Prevalence AN- 0.3%
- Lifetime Prevalence BN- 0.5%
- Lifetime Prevalence BED- 2%
- Over 50% co-morbidities

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Insulated Against Risk?

Wooldridge, 2008

- Risk factors for ED may be reduced in boys and men
  - Biology and Brain Organization- unknown
  - Temperament- unknown
  - Gender socialization- known, but unknown if related
  - Body Image
    - Objectification- may be lessening
    - Internalized thin body ideal or athletic ideal
  - Dietary restriction usually not as validated

Prevalence of Behaviors

Striegel-Moore, et al., 2009

- 40,000 men survey

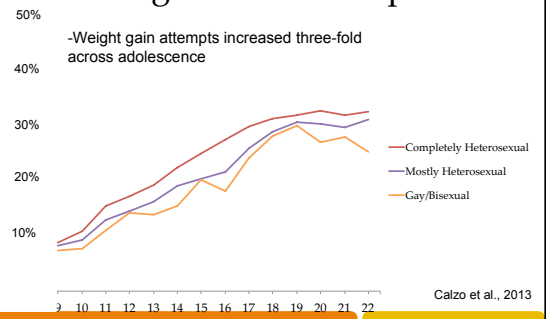
- Overeating- 26%
- Losing control of eating- 20%
- Binge Eating- 8%
- Purging- 1.5%
- Fasting- 4%
- Laxatives- 3%
- Overexercise- 4%

Compensatory Behaviors

Anderson, 2003

- Men- less purging, more exercise
- Females- compensate more to lose weight
- Males- compensate more to decrease body fat
- Note- DSM-IV defines compensation as being "to prevent weight gain" and this may exclude males

Weight Gain Attempts



Calzo et al., 2013

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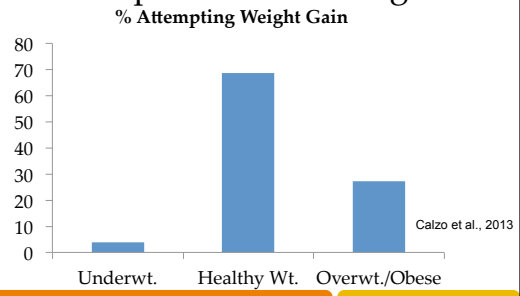
>30% of Adolescent Males Attempted to Gain Weight



Calzo et al., 2013

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How do eating disorders differ in males?

- Greater weight fluctuations
- Clearer ideal weight perception
- Premorbid obesity
- Often a pursuit of leanness and muscularity over thinness per se.
- Abuse laxatives and diet pills less frequently
- Increased prevalence of substance abuse
- Binge more often
- More likely to excessively exercise
- Familial reactions can differ, especially for fathers who see it as "female" issue and do not understand.
- Less likely to seek treatment

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Significant Results of Study of Body Image

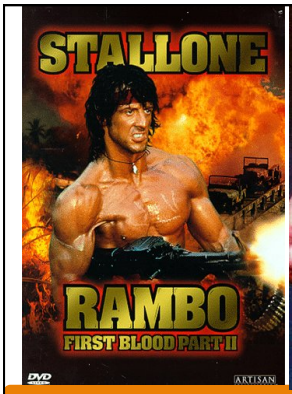
- Men perceived themselves to be fatter than they actually are.
- Men chose an ideal body with 25 pounds more muscle and 8 pounds less body fat.
- Men thought women wanted them to be more muscular and less fat than women actually did.

Significant Results of Study of Body Image in College Men (N=154)

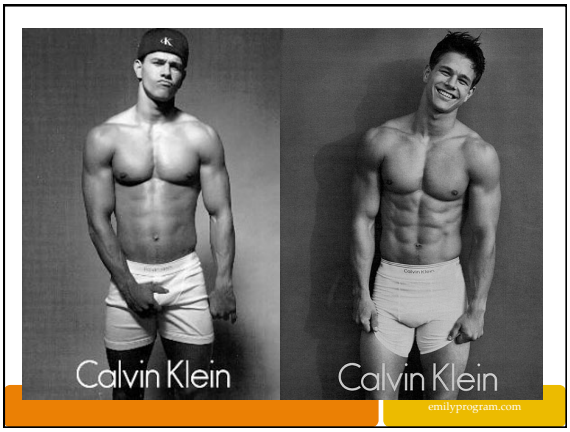
- Muscle belittlement (not fat exaggeration) associated with:
  - Depression
  - Drive for Thinness
  - Bulimia
  - Ineffectiveness
  - Body Dissatisfaction
  - Negative Self-esteem
- Men who score high on these scales at risk for eating disorders

Importance of Muscularity

- Muscularity = Masculinity
  - Strength
  - Power
  - Respect
  - Threat
  - Admiration
  - Attractiveness
  - Confidence
  - Sexual virility
  - Intertwined with identity


STALLONE
RAMBO
FIRST BLOOD PART II
DVD
ARTISAN


the twilight saga
new moon
BOUND BY DUTY,
UNLEASHED BY LOVE.
TILL LOVE FOUND HIM...
FORCE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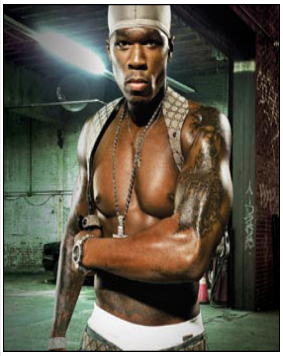

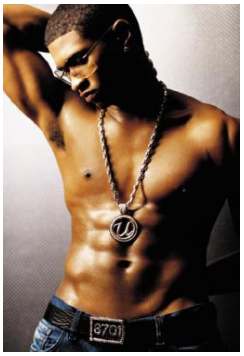

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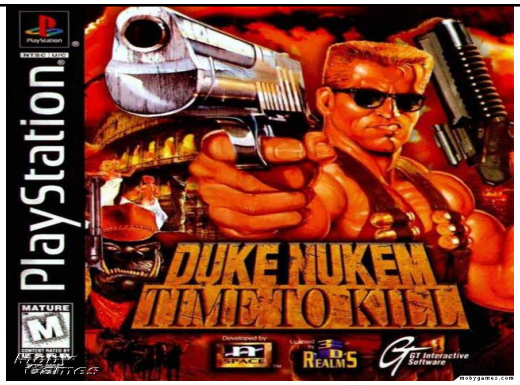


High Risk Sports

- Ballet/dance
- Bodybuilding
- Cheerleading
- Distance Running
- Diving
- Equestrian
- Gymnastics
- Swimming
- Wrestling

Prevalence of Eating Disorders in Athletes

- 33% of ballet dancers had AN/BN history
- Athletes in "thin-build" sports had greater weight concerns, higher body dissatisfaction, more dieting
- 15% of swimmers used pathogenic weight loss techniques
- Runners: 10-15% exhibit risk factors for Eating disorders

Men and Sports

- Ski jumpers and low body weight- Longman, 2010
- Jockeys and purging- Graves, 2008
- Male Cyclists and Disordered Eating- Reibl, 2007-
- ED in 33% of men in bodybuilding, gymnastics, swimming, wrestling, rowing- NEDA website

Prevalence of Eating Disorders in Athletes

<u>Wrestling:</u>

- 63% of college and 43% of high school male wrestlers were preoccupied with food during the season
- 41% of college and 29% of high school reported out of control eating between matches
- 52% of college and 26% of high school reported fasting at least once a week

Barriers To Identification/ Treatment for Athletes

- Coaches: Overwhelmed, hesitant to interfere with success, fear they have contributed to problem
- Teammates: Uncertain what can be done, may recognize similar behaviors in themselves, feel team benefits from teammates "drive"
- Parents: Uninformed, financial investments
- Athletic administrators: Concerned about legal issues, adverse publicity
- Athletes: Shame, denial, secrecy, view as necessary, don't want to let team/coach/parents down, fear being seen as "weak", "lazy", or "slacker"

Eating disorders and sexual orientation

- Community studies show that most men with eating disorders are heterosexual
- Sexual orientation is not as much of an issue as sexuality in general
- Asexuality in anorexia, lower testosterone
- Gay men more likely to dialogue, get support in community

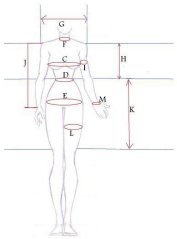
Are We asking the Right Questions?

- Alison Darcy, PhD

Introduction

- Male:female ratio of EDs in clinical settings is around 9:1
- Population-based data for adolescents yield ratios of up to 3.5:1 for AN; 3:1 for BN; 1.6:1 for BED and 2.9:1 for EDNOS
- Estimates for "partial syndromes" cause smaller ratios
- Actually, the rates from large population-based studies vary widely

Why the difference in prevalence estimates?



•ED measures are **not** gender neutral: they were developed for females and may miss aspects of male psychopathology

How EDs might differ between genders

•Many have proposed that males with EDs demonstrate less concern about weight and more concern with shape, specifically, an idealized masculine shape (Andersen, 1984; Muise et al., 2003)

•But what about
- Boys?
- Males who desire thin bodies?

Examination (EDE; Fairburn & Cooper,

- Considered to be the "Gold Standard" for ED research & practice
- Yet surprisingly little attention has been paid to its utility with males
- There are no norms for adolescent males

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The Eating Disorders Examination in Adolescent Males with Anorexia Nervosa: How Does It Compare to Adolescent Females?

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Abstract

Objective—The study aimed to explore the Eating Disorder Examination (EDE) for adolescent males with eating disorders (EDs) compared with adolescent females with EDs.

Method—Data were collected from 48 males and matched on percent median body weight (MBW) and age to 48 females at two sites.

Results—Adolescent males with anorexia nervosa-type presentation scored significantly lower than matched females on *Shape Concern*, *Weight Concern*, and Global score. They also scored lower on a number of individual items.

Discussion—The EDE has clinical utility with adolescent males with anorexic-type presentation although males' scoring ranges are consistently lower than those from adolescent females with similar clinical presentations. Males scored significantly lower on a number of items representing core symptoms such as desire to lose weight. More research is needed to gain a better understanding of the experience of adolescent males with EDs, particularly in relation to the nature of shape concern.

Participants

- Clinic and study patients at Stanford University and The University of Chicago
- N=61 11-19 year old adolescent males, and %IBW; age and site-matched females

	Male	Female		
	Mean (SD)	Mean (SD)	*t*	*p*
% MBW	83.54 (7.34)	83.94 (6.63)	0.822	0.416
Age (months)	191.09 (28.32)	185.44 (28.94)	1.877	0.070
Age (years)	15.92 (2.36)	15.45 (2.41)	1.877	0.070
BMI	17.04 (1.59)	16.84 (1.42)	1.643	0.108
Illness duration (months)	12.50 (18.39)	15.19 (17.43)	0.667	0.509
	%	%	χ^2	
Non-Caucasian	25.0	31.4	0.347	0.556
Objective binge eating episodes	12.5	18.8	0.711	0.399
Subjective binge eating episodes	25.0	29.2	0.211	0.646
Vomiting	27.1	10.4	4.37	0.036*
Laxatives	0	4.2	1.19	0.274
Diuretics	0	4.2	2.04	0.153

* Significant at $p < 0.05$ level; MBW, mean body weight; BMI, body mass index.

Matched pair subscale comparisons

•For AN patients (N=48)

•Cronbach's alphas were < 0.7 acceptability threshold for
- Dietary Restraint
- Eating Concerns

  – Males scored significantly **lower** than females on
  – Shape Concern (p = .04)
  – Weight Concern (p = .01)
  – Global Score (p = .01)

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Endorsement of items

•Males in the AN-Type group tended not to endorse:

- Empty Stomach (p < .01)
- Social Eating (p = .02) or Eating in Secret (p = .04)
- Flat Stomach (p = .02)
- Desire to Lose Weight (p = .01)

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Qualitative Study Method

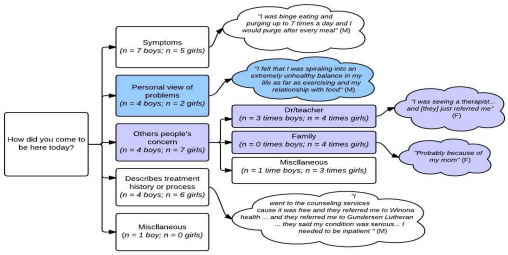
Participants

- New male patients (≤4 therapy sessions) ages 12-19 at Stanford University Eating Disorders Clinic & Park Nicollet's, MN, were approached to participate
- Female matches (age within 18 months and IBW within 10%) were recruited for comparison

Procedures

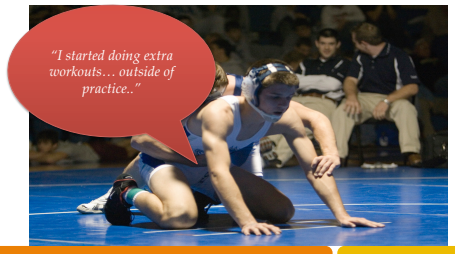
- Interview & questionnaires
- Constructed thematic maps

How did you come to be here today?



How did your problems begin?

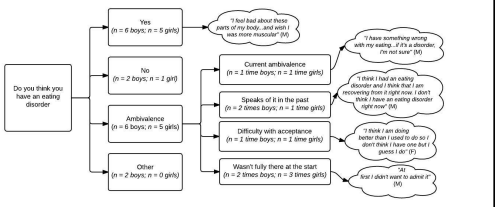
- Sport/performance a far more common avenue for boys (60%) than girls (10%)



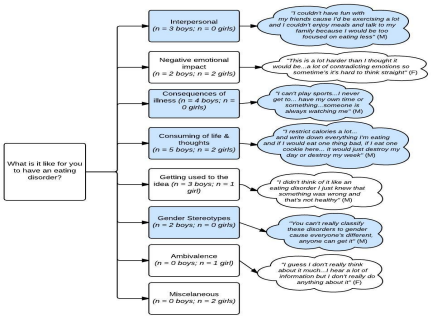
What things bother you right now?

- Thin V's muscular (40% of boys, 0% of girls)

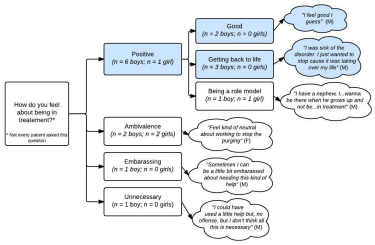
Do you think you have an eating disorder?



What is this like for you?



How do you feel about being in treatment?



"I feel bad about this parts of my body just like a girl might feel bad about this part of her body or she wishes she was skinnier versus me wishing I was more muscular …I wish I was skinnier also not just muscular so in general I would say that it's kind of the same thing you cannot really-you can't really classify these disorders to gender cause everyone's different, anybody can get it"

Conclusions of Dr Darcy

- Adolescent males and females are remarkably similar in the things that worry them and their description of etiological factors
- However, males:
  - Have a more autonomous narrative of etiology
  - Discuss EDs in a more negative light
  - Tend to talk about treatment more positively
- Could EDs be more ego-dystonic in males?

Population Studies

- Jerel Calzo, PhD

Cultural Humility

- It is impossible for anyone to know everything about a particular group or groups of individuals
  - Danger of the single story
- Humility vs. Competence
- Life-long learning
  - Don't assume; ask questions and listen

What is Gender Based Analysis (GBA)?

- Examination of differences in lives of women, men, and other gender groups, and the causes and consequences of these differences with respect to:
  - Research priorities
  - Population health
  - Policies, laws, programs, services
- GBA is a tool to promote health equity

Krieger, 2003; Hankivsky, 2012; Haworth-Brockman et al., 2008

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GBA Considerations

- Understanding gender vs. sex
  - Are gender patterns due to socially constructed sex-based roles/norms, sex-linked biological factors, both?
  - Comparison across and within genders
- Gender is heterogeneous; variation across age, cohort, race/ethnicity, sexual orientation, socioeconomic position, etc.

Krieger, 2003; Hankivsky, 2012; Haworth-Brockman et al., 2008

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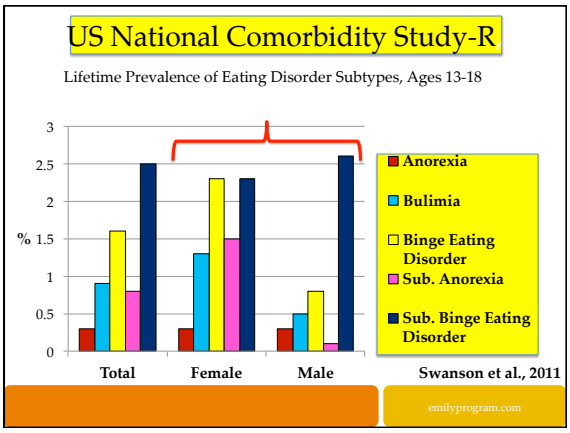
US National Comorbidity Study-R
Lifetime Prevalence of Eating Disorder Subtypes, Ages 13-18
3
2.5
2
% 1.5
1
0.5
0
Total
Female
Male
Anorexia
Bulimia
Binge Eating Disorder
Sub. Anorexia
Sub. Binge Eating Disorder
Swanson et al., 2011
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GENDER
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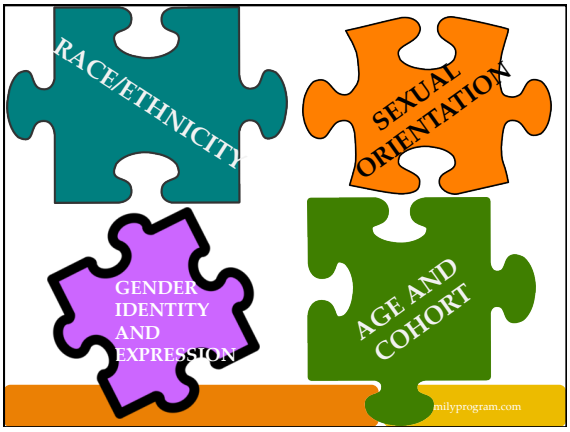
RACE/ETHNICITY
SEXUAL ORIENTATION
GENDER IDENTITY AND EXPRESSION
AGE AND COHORT
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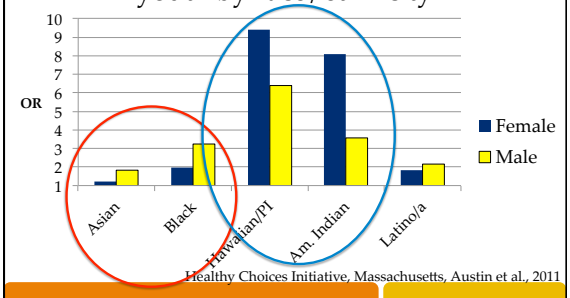
Odds of reporting disordered weight control behaviors in middle school youth by race/ethnicity



Healthy Choices Initiative, Massachusetts, Austin et al., 2011

Sexual Orientation and ED Risk

Muscularity

Sexual Minorities? →

← **Heterosexuals?**

Leanness

- Steroid and supplement use
- Dieting and overeating
- Overweight
- Hyper-exercise
- Social and emotional consequences

- Restrictive dieting
- Binging and purging behaviors
- Underweight
- Hyper-exercise
- Social and emotional consequences

Austin et al., 2009a, 2009b; Blashill & Safren, 2014; Calzo et al., 2013; McCreary & Sasse, 2000

ED Risk in Transgender Individuals

- Survey research (Diemer et al., 2015; NCHA student data)
  - Compared to cisgender heterosexual women, transgender men and women have
    - **4.6x odds** of past-year self-reported ED
    - **More than 2x odds** of past-month diet pill use and purging
- Case studies (Hepp & Milos, 2002; Surgenor & Fear, 1998)
  - Raise questions regarding
    - Body image disturbance vs. gender dysphoria
    - Pre- vs. post-transition

Data Concerns

Clinical

- Are we asking the right questions?
- Who is left out?
  - Are gender inclusive and sensitive clinical treatment available?
  - Sampling and barriers to treatment seeking
  - Caught later?
  - "The danger of the single story"
- Generalizability

General population

- Are we including the right questions?
- Who is left out?
  - Sources of data
  - Inclusion and exclusion criteria
- What's a case?
- Generalizability

Questions We Need to Answer

- Do we treat men and women together
- What levels of care should have co-ed or single gender treatment
- How to we get more treatment at all levels for men
- What is the best way to organize care for men
- How do we ensure that men and women get equal treatment

What do Men Need Now From Our Profession

- Know our history
- Know how it has impacted men
- Know how our Sociocultural beliefs have influenced our clinical beliefs
- Consider how Sociocultural issues continue to influence our field and how the impact of this is felt by all of us

Treatment

- Weight restoration and normalization of eating are essential first steps
  - Treatment at this level is similar to treatment of women with ED
  - Normalize food intake, reduce fear foods, reduce behaviors, challenge thinking (CBT) and emotional regulation (DBT)
- Men less familiar with ED
  - May describe variations of common themes
  - Lean and mean rather than thin
  - Less ambivalent about weight gain
- Less practice/facility with articulation of inner psychological experience

Treatment and Men

- Pleck, 1995
  - What works for females may not work for males
    - Shame overpowers motivation
    - Exposure reveals fundamental defects
    - Masculine imperatives as risk factors

Treatment and Men

Bunnell, 2010

- Male response to treatment may reflect gender socialization
  - Difficulty with emotion
  - Fear of dependence
  - Fight for control with therapist
  - Shame may come from need for connection

What is like to be a Man in ED

- To walk into the door of an ED Center and only see women
- To talk about your body and feelings
- To be asked if you are gay before being asked if you are fearful that you could die
- To sit in a world of caring women who value communication and connection as evidence of maturity and strength, when you have been taught the opposite

What Do We Know that Needs to be Addressed to Impact Next Steps

- 30% illness v 10% treatment
- Lack of norms
- Lack of understanding gender
- Lack of treatment options for med
- Lack of study of men
- Lack of understanding of group therpay for boys
- How to reach into the sports world
- How to talk to men
- Lack of male role models

How is Treatment Different for Men

- Less likely to seek treatment
- Deal with shame
- Masculinity issues
- Feel self-conscious of the lack of other male patients
- Male patients need male role models
- Many places do not accept boys.
- In private practice, more likely to see sicker boys than girls because got less services. May not have had a partial/ residential. Maybe just inpatient then outpatient.
- In literature, poorer prognosis. Boys seen as much more pathological than girls. More related to the length of having the eating disorder.
- Treatment works
- Assess for BDD, steroid use and muscle dysmorphia

How do Providers Help

- Explicitly address the issue of what it means that he is seeking treatment
- Be aware of own reluctance to address relational issues with male patients
- Be aware of power issues
- Think about what collaboration means to men- and if it relates to shame

How do Providers Help

- Support ED not being seen as a "girl's disease"
- Be aware of the newer literature on prevalence and diagnosis
- Think ED as an option when things don't make sense
- Ask about body image, food, body goals
- Accept that therapist skill at connection/ empathy may not be experienced in the same way and adjust

Thoughts on Treatment

- Need for more male options at treatment facilities at all levels of care
- Need to rethink diagnosis of ED to make less gender specific- i.e., include male oriented eating issues and focus as well as female oriented issues
- Need to pay more attention to early identification in pediatrician offices, sports, therapist offices
- Need for a more rational diagnostic tool
- Need to think about age groupings

What Can Clinicians Do Now for

- Make facilities and treatment centers more welcoming to men
- Have advertising include men
- Pay attention to how men speak and the language they use
- Use gender neutral language as much as possible
- Know the specific needs of men in treatment
- Make men more visible- normalize male body image and food concerns

Treatment

- Discuss media influences
- Doesn't compromise one's masculinity
- Realistic standards
- Effects of steroids
- Support/Validation
- Nutritional Rehabilitation/Education
- Cognitive-behavioral therapy
- Dialectical Behavior Therapy
- Psychotherapy
- Psychopharmacological Interventions

What Can Researchers Do

- Always include men in every study
- Don't assume we know what Eating Disorders look like in men
- Don't assume we know yet what triggers or maintains Eating Disorders in anyone
- Look at new measures
- Look at population studies
- Get excited!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