EHN CANADA

MEN AND EATING DISORDERS

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Objectives of the Presentation

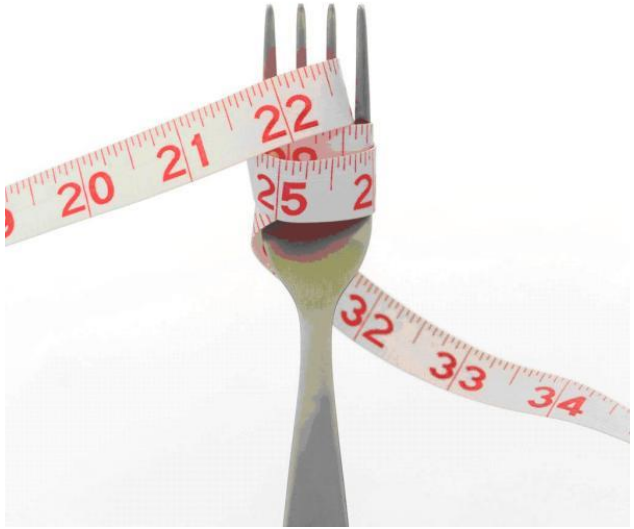
Participants will develop an understanding of:

- The types of eating disorders
  - Muscle Dysmorphia
- The prevalence of eating disorders in men
- The consequences for men
- Multifactorial influences of eating disorders
- Specific treatment considerations
- Resources – we may need to build this together

What is an Eating Disorder?

National Eating Disorder Information Centre (NEDIC), 2017

- An eating disorder is an extreme form of food and weight preoccupation
- There are strict criteria to define clinically diagnosable eating disorders
- Definitions are used to help health professionals understand how each condition develops and progresses, and how to treat people with similar symptoms
- Disordered eating & body image (subclinical)



Types of Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Other Specified Feeding or Eating Disorder (OSFED)
- Unspecified Feeding or Eating Disorder (UFED)

ANOREXIA NERVOSA

Anorexia Nervosa

American Psychiatric Association, 2017

A. Persistent restriction of energy intake relative to requirements leading to a **significantly low body weight** (no longer <85% lower than expected); less than minimally normal

B. **Intense fear of gaining weight** or becoming fat, or persistent behavior that interferes with weight gain, even though the person is significantly low weight

C. **Perceptual Disturbance/Distorted body image** with a persistent lack of recognition of the seriousness of the current low body weight

Anorexia - Specify Whether:

Subtypes

1) Restricting Type:
   - During the last 3 months, the individual **has not** engaged in recurrent episodes of binge eating or purging behavior (self-induced vomiting, laxatives, diuretics, enemas)

2)Binge-Eating/Purging Type**:**
   - During the last 3 months, the individual **has** engaged in recurrent episodes of binge eating or purging behavior

Specify: Spectrum of mild – severe

BMI more than 17= mild; less than15= extreme

BULIMIA NERVOSA

Bulimia Nervosa

American Psychiatric Association, 2017

- A1) **Recurrent episodes of binge eating** characterized by **both** of the following:

  1) Eating **large amounts of food** that are larger than most people would eat in a similar period of time (any 2 hr period) under similar circumstances

  A2) A sense of **lack of control** overeating during the episode; unable to disrupt the binge/stop

Bulimia Nervosa

American Psychiatric Association, 2017

B. **Recurrent inappropriate compensatory behaviors** in order to prevent weight gain

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least **once per week for 3 months**

D. **Self-evaluation** is unduly influenced by body shape and weight

E. The disturbance does not occur exclusively during episodes of AN

SPECIFY CURRENT SEVERITY BN; BASED ON FREQUENCY OF COMPENSATORY BEHAVIORS

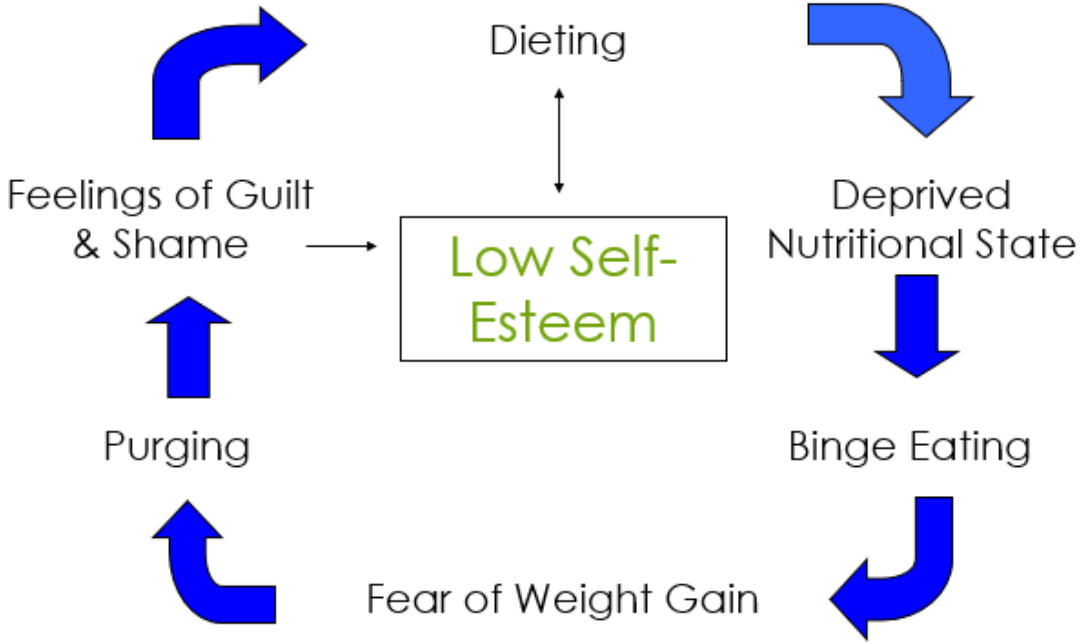
Mild = 1-3 episodes

Moderate= 4-7 episodes

Severe= 8-13 episodes

Extreme = 14 + episodes

The Bulimic Cycle



BINGE EATING DISORDER

Binge Eating Disorder

American Psychiatric Association, 2017

A1)Recurrent episodes of **binge eating** characterized by **both** of the following:

- Eating **large amounts of food** that are definitely larger than most people would eat in a similar period of time under similar circumstances
- A2) A sense of **lack of control** overeating during the episode

B. The binge-eating episodes are associated with 3 (or more) of the following:

- Eating much more rapidly than normal
- Eating until feeling uncomfortably full
- Eating large amounts of food when not feeling physically hungry
- Eating alone because of feeling embarrassed by how much one is eating
- Feeling disgusted with oneself, depressed, or very guilty after overeating

Binge Eating Disorder (continued)

American Psychiatric Association, 2017

C. Marked **distress regarding binge eating** is present

D. The binge eating occurs, on average, at least **once a week for 3 months**

E. The binge eating is **not associated** with the recurrent use of inappropriate compensatory behavior

OTHER SPECIFIED FEEDING OR EATING DISORDER (OSFED)

Other Specified Feeding or Eating Disorder (OSFED)

- Replaced Eating Disorder Not Otherwise Specified (EDNOS) in the DSM-5
- Other Specified Feeding or Eating Disorder (OSFED) includes conditions that should be considered only if the individual has an eating disturbance judged to be of **clinical significance and impairs functioning** that **does not meet the criteria** for any of the disorders in the feeding & eating disorders diagnostic class

American Psychiatric Association, 2017

MUSCLE DYSMORPHIA

What is it, and where does it belong?


Men's Health
100% USEFUL | OCTOBER 2011 £3.99
BIGGER BICEPS NOW!
40cm Arms In 1hr A Week
7 Fast Foods For Hard Abs
STRESS DEFEATED!
60-SECOND METABOLISM BOOSTERS
TOM HARDY
The UK's brightest new talent packed on 10kg of muscle for The Warrior
27 MINUTE FITNESS
Fast Gains For Time-Poor Men
RIOTOUS SEX EVERY NIGHT!
MACHINE MADE MUSCLE
Hugh Jackman's Tips For A Perfect V-Shape
Fat Burning Drugs That Really Work
HOW TO STOP A HEART ATTACK
Gareth Nedoszytko, 28, winner of the 2011 MH Cover Model Competition
THE ULTIMATE FIGHTER'S SIX-WEEK PLAN!

The Nature of Male Body Image

- It was initially thought that male body image disorders were very rare
- Recent research suggests that men are now approaching parity with women in prevalence and severity of body image dissatisfaction
- Unlike women, the bulk of male body image dissatisfaction is oriented towards the acquisition of body mass, in the form of lean muscularity, rather than losing it
- An average weight male more likely to perceive himself as underweight, whereas an average weight woman is more likely to perceive herself as overweight
- Boys as young as 6 years of age display a strong preference for mesomorphic body types

What is Muscle Dysmorphia?

- Formerly known as 'Reverse Anorexia Nervosa' (Pope at al, 1993).
  - The core body image disturbance is a belief in one's body appearing unacceptably small and weak.
  - Desire a more muscular body build (despite often being highly muscular).
  - Body shame/disgust/avoidance

- Renamed muscle dysmorphia and placed as a sub-type of body dysmorphic disorder in 1997 (Pope et al, 1997).
  - Primary disturbance is pathological muscle-building exercise behaviour.
  - Any eating disturbances are secondary & often unnecessary feature.

What is Muscle Dysmorphia? (continued)

Symptoms include:

- Preoccupation around insufficient muscularity
- Rigid schedule of muscle-building physical activity
- Deviation from this schedule results in intense anxiety around potential loss of muscularity, and immediate attempts at compensation
- Sacrifice of social or occupational activities due to the need to maintain training & diet schedule
- Avoidance of body exposure
- Illicit appearance and performance enhancing substance use
- Continued training despite physical injuries

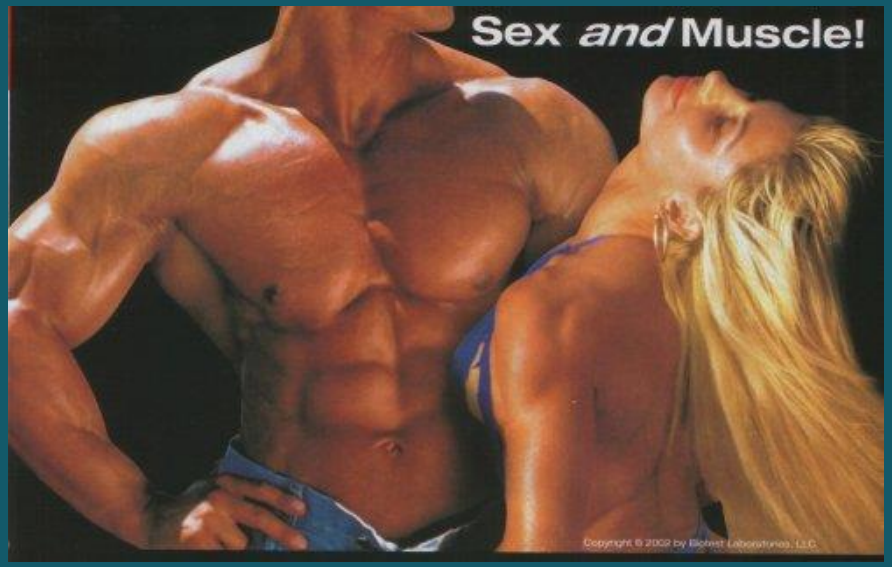
The Future of Research

- Not enough research exists to firmly conclude that muscle dysmorphia represents an eating disorder phenotype.
- However, very little research demonstrates that muscle dysmorphia differs significantly from eating disorders.
- Further research is needed in explicating how muscle dysmorphia and muscularity-oriented disordered eating fits into an eating disorder framework.
- It is important not to conflate healthful muscle-building endeavours with muscle dysmorphia.

Does Muscle Dysmorphia Feature Eating Pathology?

- Excessive preoccupation around dietary intake is central to presentations of muscle dysmorphia
- Rigid dietary regimen
- This is typically oriented around the cyclical or simultaneous consumption of protein and restriction of calories
- Disruption to dietary practices alone can result in marked escalation of muscle dysmorphia symptomatology, and immediate attempts at compensation (Murray et al., 2012)
- Men with muscle dysmorphia report comparable dietary restriction, shape- and weight concern to men with anorexia nervosa (Murray et al., 2012)
- Pathological eating practices are now deemed a central feature in muscle dysmorphia (Murray & Touyz, 2013)

“Sex and Muscle! Sex and muscle go together like success and beautiful women.”



Epidemiology

Who, when and where?

Prevalence

Men and boys represent approximately 20% of people living with an eating disorder (NEDIC, 2014)

- **Eating Disorder Prevalence Among Men and Boys -National Eating Disorders Association (NEDA) report 2015 10-year study**
- Among individuals with eating disorders, males represent the following percentages of those affected:
- **25% ANOREXIA NERVOSA**
- **36% BINGE EATING DISORDER**
- **25% BULIMIA NERVOSA**
- *A 2019 meta-analysis has reported weighted means of lifetime ED to be **8.4%** (3.3-18.6%) for women and **2.2%** (0.8-6.5%) for men*

(Galmiche, Dechelotte, Lambert & Tavolacci , 2019)

Prevalence by type of ED

- OS/UFED female to male 1.2: 1
- BED/ BN female to male 3:1ratio
- AN female to male ratio 7:1
- Sparse studies of the mortality, morbidity & health outcomes / QoL for men with ED (Murray, 2017)
- Comparable levels of distress and disability in a community sample of adolescent/adult males and females experiencing ED symptoms (Bentley & Mond, 2015)

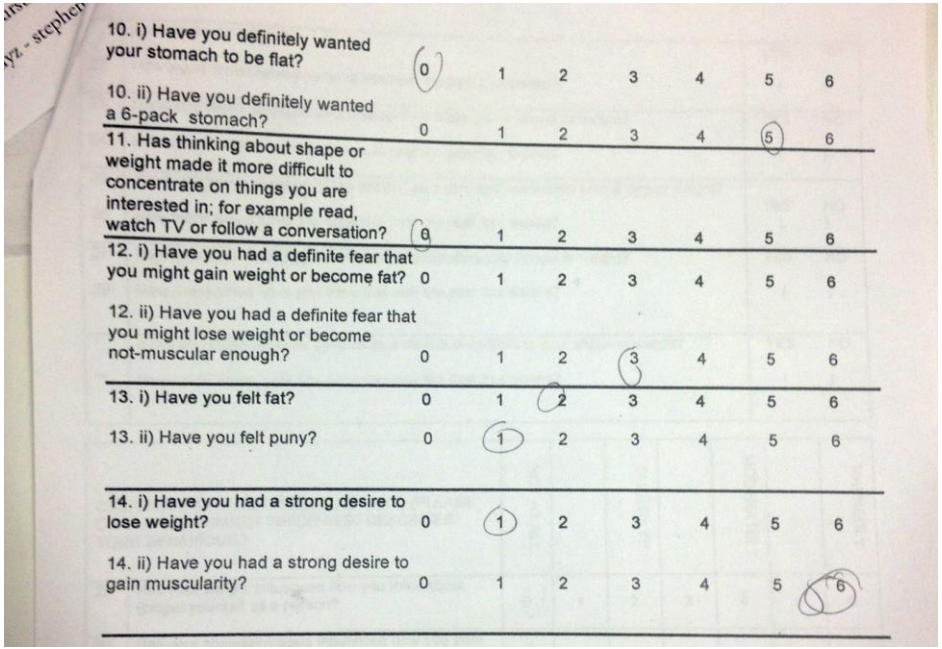
Breaking Down the Numbers

- Categories of ED are thin–centric
- Focus on calorie restriction, weight loss and fat phobia

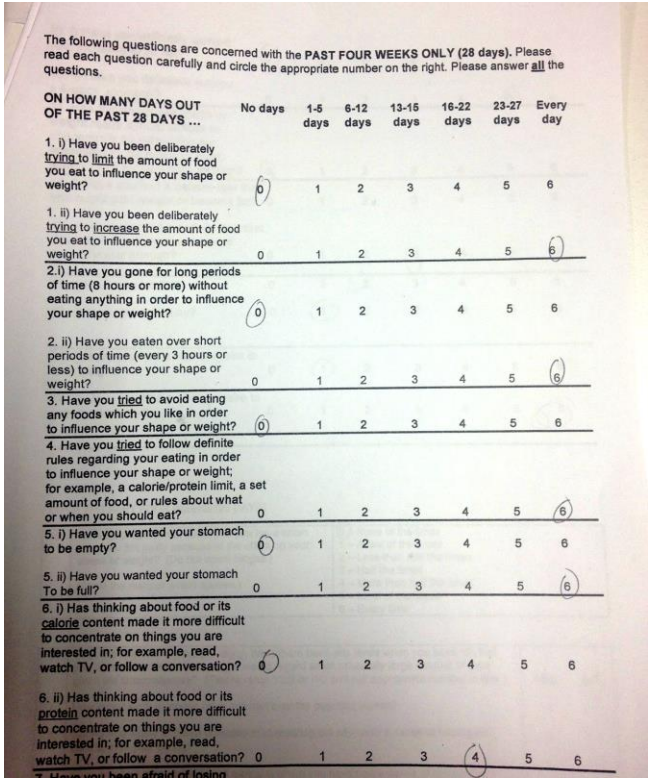
Muscle Dysmorphia:

- Mean age – 25 years
- Insight into their preoccupation 50%
- Steroid use 36%
- Suicide attempts 50%
- Lifetime history of SUD 85.7%
- On average, spend 4 hours per day thinking about 'getting bigger'
- On average, check mirrors 13 time per day (Griffiths, S)

Measuring muscularity-oriented disordered eating



10. i) Have you definitely wanted your stomach to be flat?	0	1	2	3	4	5	6
10. ii) Have you definitely wanted a 6-pack stomach?	0	1	2	3	4	5	6
11. Has thinking about shape or weight made it more difficult to concentrate on things you are interested in; for example read, watch TV or follow a conversation?	0	1	2	3	4	5	6
12. i) Have you had a definite fear that you might gain weight or become fat?	0	1	2	3	4	5	6
12. ii) Have you had a definite fear that you might lose weight or become not-muscular enough?	0	1	2	3	4	5	6
13. i) Have you felt fat?	0	1	2	3	4	5	6
13. ii) Have you felt puny?	0	1	2	3	4	5	6
14. i) Have you had a strong desire to lose weight?	0	1	2	3	4	5	6
14. ii) Have you had a strong desire to gain muscularity?	0	1	2	3	4	5	6



The following questions are concerned with the **PAST FOUR WEEKS ONLY (28 days).** Please read each question carefully and circle the appropriate number on the right. Please answer all the questions.

ON HOW MANY DAYS OUT OF THE PAST 28 DAYS ...	No days	1-5 days	6-12 days	13-15 days	16-22 days	23-27 days	Every day
1. i) Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?	0	1	2	3	4	5	6
1. ii) Have you been deliberately trying to increase the amount of food you eat to influence your shape or weight?	0	1	2	3	4	5	6
2.i) Have you gone for long periods of time (8 hours or more) without eating anything in order to influence your shape or weight?	0	1	2	3	4	5	6
2. ii) Have you eaten over short periods of time (every 3 hours or less) to influence your shape or weight?	0	1	2	3	4	5	6
3. Have you tried to avoid eating any foods which you like in order to influence your shape or weight?	0	1	2	3	4	5	6
4. Have you tried to follow definite rules regarding your eating in order to influence your shape or weight; for example, a calorie/protein limit, a set amount of food, or rules about what or when you should eat?	0	1	2	3	4	5	6
5. i) Have you wanted your stomach to be empty?	0	1	2	3	4	5	6
5. ii) Have you wanted your stomach To be full?	0	1	2	3	4	5	6
6. i) Has thinking about food or its calorie content made it more difficult to concentrate on things you are interested in; for example, read, watch TV, or follow a conversation?	0	1	2	3	4	5	6
6. ii) Has thinking about food or its protein content made it more difficult to concentrate on things you are interested in; for example, read, watch TV, or follow a conversation?	0	1	2	3	4	5	6

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Measuring muscularity-oriented disordered eating

Thinness-oriented disordered eating

$= 0 + 0 + 0 + 6 + 0 + 0 + 0 + 0 + ? + 2 + 1$

$= 9$ (15 if I gift him a 6) (mean = 0.9)

Muscularity-oriented disordered eating

$= 6 + 6 + 0 + 6 + 6 + 4 + 5 + 0 + 3 + 1 + 6$

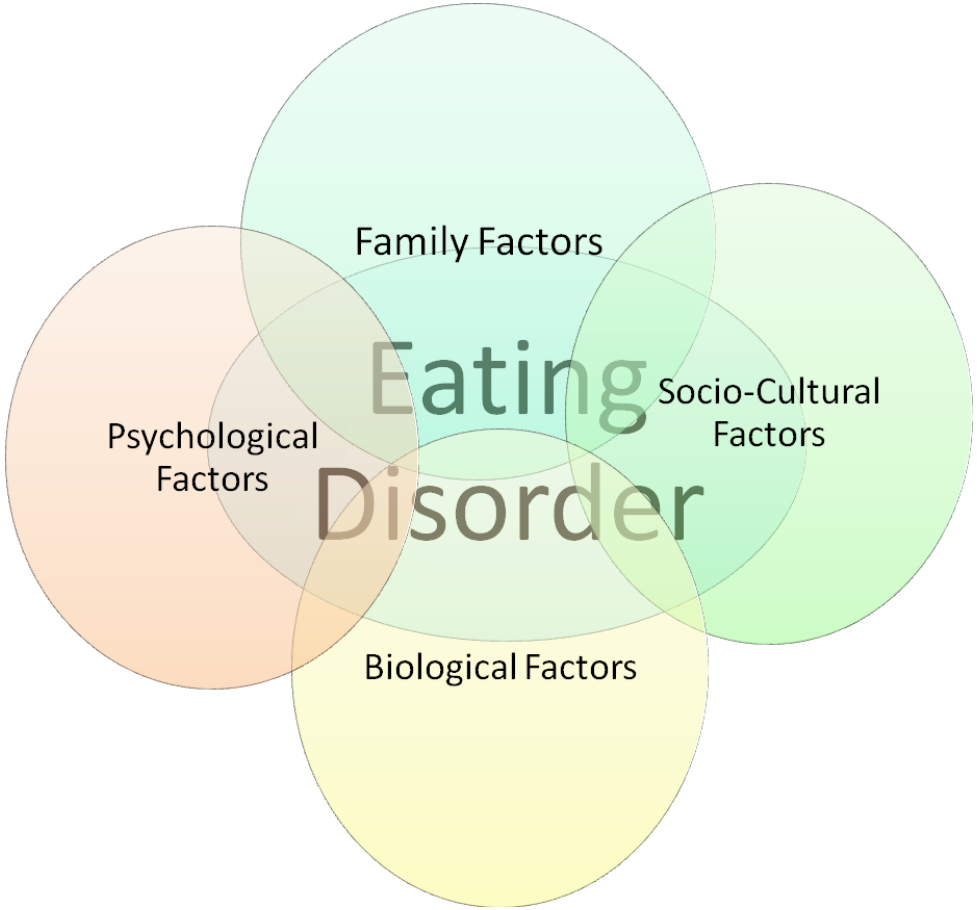
$= 42$ (mean = 3.9)

Co-Morbidities

Eating disorders are also associated with high rates of anxiety & mood disorders:

- Generalized Anxiety Disorder
- Social anxiety
- Obsessive Compulsive Disorder
- Perfectionism
- Panic disorder
- Separation anxiety disorder
- Depression
- Post Traumatic Stress Disorder (PTSD)

Spettigue, 2012


Family Factors
Eating
Disorder
Socio-Cultural
Factors
Psychological
Factors
Biological Factors

Psychological Influences – Temperamental Indicators

Those more at risk at developing an eating disorder include individuals who are:

- Sensitive; empathic
- People pleasers
- Worriers
- Perfectionistic
- Obsessive
- Rigid
- Impulsive

Other Psychological Influences

Johnston, 2011, Presentation: Core Training on Eating Disorders

- Drive for perfection
- High levels of self-control
- Identity problems
- Difficulty with independent functioning
- Fear of maturation
- Low self-esteem
- Poor body image
- Overvaluation of appearance
- Inadequate coping mechanisms
- Inability to identify inner feelings
- Feelings of ineffectiveness
- Lack of control over environment
- Interpersonal distrust
- Difficulty with assertiveness
- Unresolved conflicts

Biological/Genetic Influences

Spettigue, 2012,

Family History of the following increase risk of developing an eating disorder:

- An eating disorder
- Obsessive compulsive disorder
- Anxiety
- Depression
- Substance abuse

TREATMENT OF EATING DISORDERS

Men and Eating Disorder Treatment

What we do know…

- There is a paucity of research on men and eating disorders
- Similar levels of severity, distress and impaired functioning as women with an ED
- Men struggle to identify symptoms and engage in help seeking for ED
- Obstacles include minimization of symptoms, misdiagnosis and lack of treatment specific options
- Men 'prefer therapists that can empathize with them and have better understanding of ED'
- Value therapists who have experience treating men, and report feeling 'invisible' in female dominated treatment settings

(Thapliyal, Conti, Bandara & Hay, 2020)

“It’s so hard having this disease and being a guy. Females with eating disorders are not such a rarity, so they can feel like they fit in. The men-only group gave me a sense of freedom. I felt less exposed and more willing to admit my problems and be introspective” (Male patient)

Many men have been treated in programs that do not offer a
male only component.

“I don’t think it’s necessary and it may not benefit some men.”
(Eating disorder professional)

Principles of Treatment for Eating Disorders

- Specialized, multidisciplinary treatment team (psychiatrist, physician, dietician, therapist, social worker, psychologist, support counselor)
  - A psychological illness with medical and nutritional consequences
  - Importance of medical and psychological aspects of treatment together

- Importance of education and support for patient and family
- Programming that is tailored to individual needs and preferences of men (offers options) ; potential role for men's only services
- MATT; Male Assessment and Treatment Track Hotel Dieu Kingston, ON

Principles of Treatment for Eating Disorders (continued)

Spettigue, 2012

Medical &Nutritional Traditional approach:

- Re-nourishment; reversal of the effects of starvation; 'food is the medicine'
- Meal plan,
- 'Mechanical eating'
- Medical management and weighing
- Decreasing opportunity for symptoms of binging, purging, restricting and over-exercising

Treatment vs. Support

- Rather than attaining diagnostic or other medically derived criteria for treatment, support focuses on personal and lived experiences (Shepherd et al, 2008; Slade et al, 2008)
- Support can be seen as a community-based therapy that is often given in the form of groups and/or through an outpatient setting
- Group support serves as a link between hospital programs and community support example: Sheena's Place and NEDIC

Benefits of Group Support

Wanlass, Moreno & Thomson, 2005

- Interpersonal growth
- Reduce isolation, shame, low self-esteem & difficulty identifying feelings
- Increase communication skills, such as reflective listening, assertive confrontation, and conflict resolution
- Acts as a link to receive support during the transition from inpatient to outpatient care
- Consistent meeting each week provides continuity to aid in the transition from highly structured inpatient treatment programs
- Provide a safe place to report successes and challenges of new behaviors and skills

QUESTIONS?