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# **Eating Disorders in Men: Underdiagnosed, Undertreated, and Misunderstood**

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*This article provides a survey of eating disorders in men, highlights the dramatic rise in eating disorders, identifies issues specific to males, and suggests areas for research and intervention. This survey concludes that men with eating disorders are currently under-diagnosed, undertreated, and misunderstood by many clinicians who encounter them. Ongoing research addressing these issues is expected to result in assessment tools and treatment interventions that will advance positive outcomes for men with eating disorders.*

## INTRODUCTION

Males suffering from eating disorders and body image issues have an immense stigma to overcome and, as a result, have been significantly neglected in both diagnosis and treatment. Stereotypes of eating disorders inhibit the availability of evidence-based treatment for males and falls short of the successful management of gender specific problems (Morgan, 2008).

Clinicians that treat males with eating disorders are likely to be highly challenged. Resources are limited as treatment paradigms have been geared toward females. Though this trend is beginning to change, there is still a

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need for more research focusing on males and their gender-specific issues in order to better understand and treat them successfully.

Males accounted for roughly 10% of anorexia nervosa and bulimia nervosa eating disorder patients in Weltzin's study (2005), with the number of men struggling from bulimia nervosa being more than those who struggle with anorexia nervosa. However in 2007, a study reported 25% of anorexia and bulimia cases are males (Hudson, Hiripi, Pope, & Kessler, 2007). The National Institute of Mental Health reports that roughly one million males struggle with eating disorders (2008), which is likely an underestimate. With this recent research, it appears that the incidence among men as well as the prevalence is increasing as more men are either seeking help or are being identified in treatment. Further studies on the differences between men and women with eating disorders are needed. Until more interest and attention is focused on male eating disorder issues, men will continue to be under-diagnosed, undertreated, and misunderstood.

## ISSUES FOR MEN

There are a number of areas to consider when examining gender specific issues in men. Included among these are: weight history, sexual abuse and other trauma, gender orientation, depression and shame, exercise and body image, co-morbid chemical dependency, and media pressures.

### Weight History

One important distinction, in which men differ from women is their weight histories. Men frequently have been mildly to moderately obese at one point in their lives before developing an eating disorder, and were particularly susceptible if obesity was present in childhood. This contrasts with women as they generally *felt* fat before using compensatory behaviors to lose weight, however most women usually had a normal weight history (Andersen, 1999).

Compensatory behaviors, such as exercise, are also used more by men than women in order to avert the potential of developing medical complications that their fathers had developed. Most women do not use compensatory behaviors as a method of preventing the development of medical illness, but instead are founded on achieving thinness (Andersen, 1999).

The issue of weight concerns among males often is influenced by athletic achievement. More men than women are motivated to lose weight, or sometimes to gain weight, to achieve optimal performance in sports, and even in some cases, to be eligible to compete. This is also true in the cases of injury: resulting in attempts to avoid weight gain due to an inability to exercise (Andersen, 1999).

## Sexual Abuse and Other Trauma

A literature review of the correlation between sexual abuse and eating disorders revealed that approximately 30% of eating disordered patients had a history of sexual abuse (Connors & Worse, 1993). For males, sexual abuse is likely underreported due to a disproportionate amount of shame and stigmatization that accompanies abuse for men versus women. Because of underreporting, there appears to be a smaller number of males with a documented history of sexual abuse. Most perpetrators of sexual abuse are males; therefore, males who are victims of sexual abuse may develop issues around sexual orientation and/or fear of experiencing sexuality. Through disordered eating, specifically anorexia, males struggling with these issues may deny natural hormonal mandates as a solution to their sexual orientation crisis, and therefore become asexual as a way to avoid sexual issues altogether (Morgan, 2008).

In Schwartz and Cohn (1996) it was reported that, “by the 1980s numerous publications found . . . 1 in 3 females and 1 in 7 males [were victims of sexual abuse]” (p. x).

A major symptom of eating disordered individuals with a history of sexual abuse is body image disturbance. This suggests that addressing distorted body image is an essential aspect of treatment.

Physical and psychological traumatic experiences can vary in many ways, including childhood sexual abuse and childhood bullying. Childhood bullying is common in males, who may react to this trauma by conscious or unconscious manipulation of body shape. Generally this manipulation is focused on becoming more “masculine.” By becoming physically larger, men try to protect themselves from being an ongoing victim of aggression (Morgan, 2008).

## Sexual Orientation

“Most men with body image disorders are straight and most gay men do not have body image disorders,” reports Morgan (2008, p. 64). With that in mind, symptoms related to eating disorder issues were found to increase 10 times more with gay and bisexual men than with heterosexual men (Strong, Williamson, Netemeyer, & Geer, 2000). Also, in a sample of 135 males with eating disorders, 42% of the bulimic patients considered themselves to be either gay or bisexual. In the same study, 58% of the men described themselves as “asexual” (Carlat, Camargo, & Herzog, 1997). Concern over body shape and weight is prevalent among homosexual males and can become pathological. However there are subcultures within the gay culture; not all of which stress body image. More heterosexual females struggle with body image concerns than gay males. Therefore being a gay male is *not*, in itself, predictive of males developing an eating disorder or muscle dysmorphia;

however homosexuality is an indication for a male to be more at risk of developing a disorder (Morgan, 2008).

Some men, who experience confusion around sexual orientation, find comfort in weight loss as a product of restricted eating. In anorexia, severe weight loss creates changes in the body's physiology, including lower testosterone levels, resulting for some, in asexuality. For some males, this sidesteps the issue of resolving sexual orientation conflicts by inhibiting libido all together. For these males, recovery can be difficult as the process of re-gaining weight reverses these physiological factors, thus re-starting puberty (Morgan, 2008).

Though few studies exist which have examined the influence of gender role orientation on disordered eating with males, there is evidence that men with "undifferentiated" and "feminine" gender roles have a higher prevalence of disordered eating than men with "masculine" and "androgynous" roles. Therefore it is recommended that professionals involved with treating disordered eating be aware of the influence of gender roles and gender differences in determining the presence or absence of disordered eating. It is also suggested that these influencing factors be addressed with distinctive approaches specific for males and females (Pritchard, 2008).

### Depression and Shame

Males with eating disorders often experience depression and shame. "Hidden depression drives several of the problems we think of as typically male: physical illness, alcohol and drug abuse, domestic violence, failures in intimacy, self-sabotage in careers" (Real, 2003, p. 22), and now eating disorders are added to this list. In today's world, men are expected to hide their vulnerabilities: including depression and shame which are associated with the stigma of being "feminine" (Real, 2003).

Underreporting of eating disorder symptoms (similar to what was mentioned previously about sexual abuse) is a major inhibitor to diagnosis, treatment, and accurate research for advancement in this area. The promotion of an accepted culture, which allows vulnerability in men may create an environment in which male reporting would improve in frequency and accuracy.

### Exercise and Body Image

A frequent behavior among eating disordered men is excessive exercise; which can become "addictive" and is sometimes referred to as Anorexia Athleticism. Some men use exercise as a compensatory behavior for caloric intake; while others are caught in a vicious cycle of exercising for weight loss to promote better health, but find themselves in a "runaway diet," resulting

in self-starvation. Restlessness and physical over-activity result; as often seen in those with anorexia nervosa. Ultimately, other areas of the person's life are affected, such as interference with work, social activities, or just meeting day-to-day responsibilities (Morgan, 2008).

*Muscle Dysmorphia*, rather than *Reverse Anorexia Nervosa*, is currently the preferred term for the disorder as it is not technically an eating disorder as *Reverse Anorexia Nervosa* implies. (The term *dysmorphia* is used in order to link the disorder to a more general diagnosis of *Body Dysmorphic Disorder*). In *Body Dysmorphic Disorder*, an individual is over-concerned, or obsessed, with certain parts of their bodies, in which they misperceive as being irregular or extremely unattractive. In *Muscle Dysmorphia*, a person is focused specifically on muscle mass or body size, making muscle dysmorphia a *subtype* of body dysmorphic disorder (Pope, Phillips, & Olivardia, 2002). However, in the proposed *DSM-V* diagnostic criteria for muscle dysmorphia, there is no mention of food and diet. There seems to be a considerable overlap between this disorder and an eating disorder. Many men who struggle with muscle dysmorphia, struggle with an eating disorder as well. It has been recommended that treatment interventions similar to those used for eating disorders be applied in cases of muscle dysmorphia (Morgan, 2008).

There is another aspect of substance abuse which is specific to males: the use of steroids and growth hormones. This is common when muscle dysmorphia is present. The rate of anabolic steroid use among young males is roughly equal to that of anorexia and bulimia in young females (Schooler & Ward, 2006.) Pope et al. (2002) state that over 2 million males of all ages in the United States have used anabolic steroids at some point. These drugs produce swift changes in muscle mass and have very few initial side effects for the user. However, long-term use has been linked with many physical and psychological complications. Some of these side effects produce prostate enlargement, high cholesterol, depression, and suicidal ideation as a withdrawal symptom (Mosley, 2008). Steroids and other hormones are often used by men with body image concerns, which are greatest for those with a less than average weight for height. These men generally have a high drive for bulk, paired with a high drive for thinness or lean body mass. As a result they are at risk for developing disordered eating habits such as bingeing, purging and restricting, along with the abuse of hormones (Blouin & Goldfield, 1994).

### Comorbid Chemical Dependency

Past research reveals that people with eating disorders often struggle with comorbid psychiatric disorders such as substance abuse. A large number of studies have investigated this issue and found that people with eating

disorders have a higher frequency of substance abuse than people who do not have eating disorders, and likewise, those who struggle with substance abuse disorders present a higher level of issues with food (Dunn, Larimer, & Neighbors, 2002). Other studies shows that roughly 24% of people struggling with bulimia also struggle with alcohol abuse or dependence (Costin, 2007) and that approximately 57% of males with binge eating disorder struggle with substance abuse issues compared to only 28% of females with binge eating disorder (American Psychiatric Association, 2006).

One connection to the use of substances is to control weight. Stimulants are increasingly used to manage weight. Unfortunately, it is common, while in treatment, for these individuals to be diagnosed strictly with a substance abuse disorder while their eating disorder is overlooked. Due to this tendency to under-diagnose, many individuals are only in treatment for substance abuse with little, if any, attention to food and body issues (Costin, 2007). It is usually recommended that individuals with the dual-diagnosis of an eating disorder and substance abuse be treated for the substance abuse primarily at the beginning of the course of treatment; as it is generally believed that it is ineffective to treat a person with an eating disorder while actively abusing an addictive substance. However, there is still very minimal information to recommend the best course of treatment; and it is possible that the most effective strategy would involve an intervention that includes both disorders (Mitchell, Specker, & Edmonson, 1997).

## Media Pressures

Analysis of popular magazine content has documented an increase in the frequency of images showing semi-naked men over the past 30 years. This finding, paired with the increase in popular culture's intense focus on muscularity, has had a major influence on current male body image ideals (Halliwell, Dittmar, & Orsborn, 2007).

Pope et al. (2002) revealed that action figures produced between the years of 1964 and 1998 have consistently become more muscular over the years. These action figures have become portrayals of the male body which are beyond the limits of realistic human attainment, having increasingly smaller waists, while gaining larger chests and larger biceps. These researchers also studied *Playgirl* magazines from 1974 to 1997, finding that recent models had bodies that were measured to be unattainable (applying the *fat-free mass index*) without the use of anabolic steroids. They found that the average male model lost roughly 12 pounds of fat, while gaining roughly 27 pounds of muscle over a period of 25 years (Pope et al., 2002).

It has been found that men report experiencing increased depression and increased body dissatisfaction with regard to muscularity, after viewing television advertisements which show men with so-called *ideal* bodies. The current muscular ideal of the male body is becoming less and less realistic

for men and is a likely influence on the increase in male body dissatisfaction, use of excessive exercise and steroids (Halliwell et al., 2007).

## INTERVENTIONS

Based on current information, there is no indication that males would have a poorer prognosis than females; and, actually, anecdotal reports suggest that males may have better outcomes because of their tendency to want to “fix” problems. Regardless, treatment interventions for males should include the standard approaches used for females as well as approaches which address male specific issues (Andersen, 1999).

One male specific area is that of body dysmorphic disorder, and more specifically, muscle dysmorphia. Targeting this issue with an understanding of how male body image concerns are different from female concerns is a great asset to practitioners in the field. This understanding may help men work towards changing their body image ideal through forming a new understanding of masculinity and placing more value on personal qualities rather than appearance.

All-male therapeutic groups are generally recommended as they encourage vulnerability through empathy found in the process of group work. When a man takes a risk and begins to disclose his issues with food or body image, other men feel safer revealing their own issues which may also dispel the belief that eating disorders are a “women’s disease.” This often is a catalyst for identifying each individual’s eating disorder issues, as well as associated issues of depression, self-esteem and various comorbid addictions.

Incorporating a focus on issues unique to males such as weight history, sexual abuse, trauma, gender orientation, body image, the abuse of exercise, media pressures, and the unique dynamic of male depression and shame, may ultimately lead to improved intervention techniques. This approach should be paired with the other forms of intervention that are effectively used with women, as well as evidence-based modalities such as cognitive behavioral therapy, dialectical behavior therapy, and other psychotherapeutic methods.

## SUMMARY

Research, to date, indicates that male weight and body image concerns are different from those of females. Studies show that males do not generally have a firm drive for thinness and are prone to have as much desire to *gain* weight as they are to *lose* it. This desired weight gain involves men as striving to attain a muscular and sometimes lean build. Currently most body image/dissatisfaction assessments tend to place emphasis on feminine ideals

and focus on areas of importance for females (Ochner, Gray, & Brickner, 2009). As a result, there seems to be an invalid approximation of body image dissatisfaction levels in males due to the traditional focus on weight (Grossbard, Lee, Neighbors & Larimer, 2008). Further evaluation of the areas of concern for males would likely improve the validity and effectiveness of body image assessment scales for men.

It is believed that there are significant differences in men and women with eating disorders. These differences are present in the predisposing, precipitating, and perpetuating factors for an eating disorder. By researching these factors in more detail, better empirical data will lead to more effective and conclusive diagnostic criteria, assessment tools, and treatment interventions.

Studies show that men are less likely than women to engage in “typical” bulimic compensatory behaviors, such as vomiting or laxative abuse; while having more of an inclination to use excessive exercise as a compensatory method for weight and body shape control. Men also report less of a sense of being out of control during a binge than women do and that anger can trigger a binge episode, while women seem to binge in order to restrain their sense of anger (Weltzin, 2005). The use of assessment tools, which places emphasis on compensatory behaviors, binge habits, attitudes about food, and emotional triggers in males, would likely improve accuracy of reporting by males, as well as lead to the development of appropriate interventions.

Studies which focus on male weight history, sexual orientation, and body image ideals, as well as the effects of sexual abuse, comorbid addictions, media influences, excessive exercise, depression, and shame are needed.

Promotion of awareness of these issues is a crucial aspect to advance this field; as awareness may, in turn, promote environments in which men are able to talk about their food and body issues. Currently there are few resources for males to use for support. Many men do not even recognize these issues, as eating disorders have largely been viewed as a women’s problem. Problems with excessive exercise are often ignored as over exercise may create a deceptively healthy outward appearance, unlike those with anorexia, bulimia, and binge eating disorder, when exercise is not a compensatory behavior.

Finally, encouragement of a culture which allows for male vulnerability is a major goal. Men are not supposed to be emotionally vulnerable in our present culture, yet they encounter pressures on a daily basis to be more muscular and meet the current male body shape ideals. This is deleterious for many men as they feel pressure from many sources to meet mainstream society’s definition of *masculine*. Also, men are not supposed to be focused on how they look, so why would they reveal body image or weight concerns? This is a major hurdle for the advancement and better understanding of men with eating disorders.



## REFERENCES

- American Psychiatric Association Work Group on Eating Disorders. (2006). *Practice guidelines for the treatment of patients with eating disorders*. Retrieved from [http://www.psychiatryonline.com/pracGuide/loadGuidelinePdf.aspx?file=EatingDisorders3ePG\\_04-28-06](http://www.psychiatryonline.com/pracGuide/loadGuidelinePdf.aspx?file=EatingDisorders3ePG_04-28-06)
- Andersen, A. (1999). Eating disorders in males: Critical questions. In R. Lemberg & L. Cohn (Eds.), *Eating disorders: A reference sourcebook* (pp. 73–79). Phoenix, AZ: Oryx Press.
- Blouin, A., & Goldfield, G. (1994). Body image and steroid use in male bodybuilders. *International Journal of Eating Disorders*, *18*, 159–165.
- Carlat, D. J., Camargo, C. A., & Herzog, D. B. (1997). Eating disorders in males: A report on 135 patients. *American Journal of Psychiatry*, *154*, 1127–1132.
- Connors, M. E. & Worse, W. (1993). Sexual abuse and eating disorders: A review. *International Journal of Eating Disorders*, *13*, 1–11.
- Costin, C. (2007). *The eating disorder sourcebook: A comprehensive guide to the causes, treatments, and prevention of eating disorders*. New York, NY: McGraw-Hill.
- Dunn, E., Larimer, M., & Neighbors, C. (2002). Alcohol and drug-related negative consequences in college students with bulimia nervosa and binge eating disorder. *International Journal of Eating Disorders*, *32*, 171–178.
- Grossbard, J., Lee, C., Neighbors, C., & Larimer, M. (2008). Body image concerns and contingent self-esteem in male and female college students. *Sex Roles*, *60*, 198–207.
- Halliwell, E., Dittmar, H., & Orsborn, A. (2007). The effects of exposure to muscular male models among men: Exploring the moderating role of gym use and exercise motivation. *Body Image*, *4*, 278–287.
- Hudson, J., Hiripi, E., Pope, H., & Kessler, R. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry*, *61*, 348–358.
- Mitchell, J., Specker, S., & Edmonson, K. (1997). Management of substance abuse and dependence. In D. Garner & P. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 415–423). New York, NY: Guilford Press.
- Morgan, J. (2008). *The invisible man: A self-help guide for men with eating disorders, compulsive exercise, and bigorexia*. New York, NY: Routledge.
- Mosley, P. (2008). Bigorexia: Bodybuilding and muscular dysmorphia. *European Eating Disorders Review*, *17*, 191–198.
- National Institute of Mental Health. (2008). *Eating disorder statistics*. Retrieved from [http://www.gurze.com/client/client\\_pages/printable\\_pages/eatingdisorderstats.html](http://www.gurze.com/client/client_pages/printable_pages/eatingdisorderstats.html)
- Ochner, C., Gray, J., & Brickner, K. (2009). The development and initial validation of a new measure of male body dissatisfaction. *Eating Behaviors*, *10*, 197–201.
- Pope, H., Phillips, K., & Olivardia, R. (2002). *The Adonis complex: How to identify, treat, and prevent body obsession in men and boys*. New York, NY: Touchstone.
- Power, C. (2005). Food and sex addiction: Helping the clinician recognize and treat the interaction. *Sexual Addiction & Compulsivity*, *12*, 219–234.

- Pritchard, M. (2008). Disordered eating in undergraduates: Does gender role orientation influence men and women the same way? *Sex Roles*, 59, 282–289. doi: 10.1007/s11199-008-9449-8
- Real, T. (2003). *I don't want to talk about it: Overcoming the secret legacy of male depression*. New York, NY: Scribner.
- Schooler, D., & Ward, M. (2006). Average Joes: Men's relationships with media, real bodies, and sexuality. *Psychology of Men & Masculinity*, 7(1), 27–41.
- Schwartz, M., & Cohn, L. (1996). *Sexual abuse and eating disorders*. New York, NY: Brunner/Mazel.
- Strong, S. M., Williamson, D. A., Netemeyer, R. G., & Geer, J. H. (2000). Eating disorder symptoms and concerns about body differ as a function of gender and sexual orientation. *Journal of Social and Clinical Psychology*, 19(2), 240–255. doi: 10.1521/jscp.2000.19.2.240.
- Weltzin, T. (2005). Eating disorders in men: Update. *Journal of Men's Health & Gender*, 2, 186–193.