MALE ANOREXIA NERVOSA: AN EXPLORATORY STUDY

BY

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(Abstract)

Anorexia nervosa is a serious problem that affects over one million males yearly. It is often misdiagnosed and overlooked completely in clinical, medical and school settings because of the misperception that it is a disorder exclusively present in females. The DSM-IV largely contributes to this misnomer due to the gender-biased criteria.

The purpose of this exploratory study was to identify the etiology and clinical characteristics of male anorexia and devise a more comprehensive definition of anorexia nervosa that encompasses both males and females. An additional purpose was to develop an instrument that identifies risk factors associated with anorexia nervosa in males and aid mental health and medical practitioners in making this diagnosis.

A review of literature illuminated unique features of the male anorexic as well as characteristics shared with females. The Assessment of Anorexia Nervosa in Males Questionnaire (AANMQ) was developed for this study to assess an expert panel's clinical observations regarding potential misdiagnosis and treatment gaps among males with anorexia nervosa. This panel included one male anorexic, one parent of an anorexic male, and eight mental health and medical practitioners who were selected based on personal and clinical experiences working with male anorexics. Data were collected via face-to-face and telephone interviews. A compilation of literature and the expert panel's responses to the AANMQ resulted in the content suggested for the Assessment of Male Anorexia Nervosa (AMAN), a diagnostic inventory that provides a comprehensive profile specific to male anorexics. This instrument is to

be used by mental health and medical practitioners for the diagnosis of this disorder. Even when anorexia nervosa is correctly diagnosed, services for males are selective and inadequate due to treatment models being geared toward a female population. The AMAN compensates for the missing elements and gender-biased nature of DSM-IV and permits accurate assessment and diagnosis of male anorexia.

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CHAPTER ONE

Introduction

Background and Theoretical Framework

> For some time now, my mother has been encouraging me to write a book about my screwed-up life and my experiences with anorexia nervosa and depression. I've never given this idea much consideration. Because of this depression, I just haven't had the motivation. However, now that I am not working, I figure I may as well give it a shot. …Talk about a waste. These past couple of years epitomize my life-a total waste…. First, the facts that make me an "official" anorexic. The so-called professionals, your $100-per-hour, know-it-all doctors, will list many symptoms and characteristics of anorexia. The bottom line is that I am 5'9" and feel fat, despite weighing only 75 pounds. Just for the record, I am white, American, Jewish, and twenty-five years old…my name is Michael Krasnow. What sets me aside from most other anorexics is that I am male (Krasnow, 1996, p. 1).

Only recently has any attention been given to anorexia nervosa and issues of body image in males. Much of the research to date has been restricted to females falsely believing that this is a problem unique to young women. This sentiment has been reinforced by scholarly publications, the media, and popular magazines. O'Hehir (1999) states that the emphasis on eating disorders and body image problems has focused solely on women and has been:

> reinforced by the feminist assumption that the mania is "caused" by the tyranny of the media-fueled beauty cult. It is women, not men, who have been pegged as the "victims" of this obsessive focus on looks, and nothing fuels the victim image

more satisfyingly than an emaciated, anorexic woman. But, recent studies, though they have received little attention, have illuminated a startling and troubling fact: one in six cases of eating disorders are diagnosed in men (p. 104).

Eating disorders have long plagued our society and have a rich history. Richard Morton in the late 1600's is credited for recognizing the first case in London, England. Interestingly, this initial case description was of a young adolescent male. There are additional accounts of this disorder that reach back as far as the 9th century, but it was not until the late 19th century that anorexia nervosa was actually acknowledged as a distinct disorder when William Gull, a physician at Guy's Hospital in London and Ernest-Charles Lasegue and a Professor of Clinical Medicine of the Faculty of Paris, reported patients in their care suffering from this strange malady and simultaneously published papers on the topic.

Anorexia nervosa, defined as an eating disorder that is characterized by an individual's refusal to maintain a normal body weight, is an enigma that continues to challenge both the mental health and medical community. This disorder is triggered by many different motivations but perhaps the most significant underlying factor is satisfaction with one's body shape and self-esteem (Abell & Richards, 1996). Carlat, Carmago, and Herzog (1997) suggest there are a number of similarities and risk factors associated with eating disorders in general. These include:

- Nine out of ten affected are female (estimates range from two to seven million women with as many as 100,00 to one million men)
- In 90% of the cases, the onset begins between the ages of 15-30 years.
- The majority of individuals with anorexia are Caucasian, college-educated females from middle-to-upper-class socioeconomic groups.
- Most are members of an intact, yet enmeshed family.

- Dieting appears to be a precursor to the development of an eating disorder, especially in the adolescent or early adult years.
- Many who engage in anorexic behavior can be labeled as "super-achievers."
- Many possess a distorted body image.
- Depression is frequently observed.
- Personality disorders are common with histrionic, borderline, and passive-aggressive features most notably observed.
- Sociocultural factors influence this behavior with the emphasis on thinness for females and muscularity and leanness for males.
- Low self-esteem is often present.
- Asexuality or homosexuality is common among males.
- Alcohol and other drug abuse are prevalent.

In addition to the anorexic exhibiting a refusal to maintain a minimal normal body weight, a fear of gaining weight, and having a distorted perception of their body shape, The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV, American Psychiatric Association, 1994) reports,

> The self-esteem of individuals with Anorexia Nervosa is highly dependent on their body shape and weight. Weight loss is viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control. Though some individuals with this disorder may acknowledge being thin, they typically deny the serious medical complications of their malnourished state (p. 540).

Crisp (1980) believes that anorexia nervosa should be viewed as both a biological and psychological illness as starving one's self can result in a number of serious complications such as stunted physical and social development or even death. Hsu (1990) offers that the anorexic client ceases food intake because he/she is afraid to eat rather than he/she is experiencing a loss of appetite. Indeed, it has been well documented that the anorexic regularly experiences an intense internal gnawing with sharp hunger pangs that regularly reminds the person of the need for nutrition. However, it is precisely the ability to ignore this signal that allows the anorexic to feel empowered and in control.

Statement of the Problem

The problem for this study is that there are distinct characteristics of the male anorexic that have been ignored by the mental health community resulting in underdiagnosis and mismanagement of this disorder. Two major aspects of this problem are:

1. Characteristics of the adolescent male anorexic are unclear to many counseling professionals.
2. The DSM-IV definition is inadequate and gender biased.

Purpose

The purpose of this study was threefold and included the following:

1. Identify the characteristics of the male anorexic.
2. Develop a more comprehensive definition for anorexia nervosa that encompasses both males and females.

3. Develop an instrument for mental health and medical professionals to use for assessing anorexia nervosa in males.

Research Questions

In order to achieve the purpose of this study, three specific questions were addressed.

1. What are specific characteristics of male anorexia?

This first question examined characteristics of the male anorexic and what mental health and medical professionals believe essential for assessing anorexia nervosa in males. Specifically, this research question was addressed by reviewing the literature in Chapter 2. Additionally, it was addressed by a questionnaire designed by the researcher to examine the participants knowledge of male anorexia. This instrument, entitled Assessment of Anorexia Nervosa in Males Questionnaire (AANMQ), was developed from the literature review and a pilot study involving Master's level graduate counseling students. (Appendix B).

2. How can the DSM-IV definition of anorexia nervosa be broadened to provide a more comprehensive definition that includes males and females?

The DSM-IV definition of anorexia nervosa is gender-biased as it makes no reference to endocrine function in males (Bowers & Anderson, 1994-95). Therefore, the second research question considered the extent to which the current definition of anorexia nervosa could be broadened to include males and females. This question was addressed through: (a) the literature review in Chapter 2 and (b) interviews with mental health and medical professionals and their responses to the AANMQ.

3. What items appear necessary for inclusion on an instrument for recognition and accurate assessment of anorexia nervosa in males?

This research question considered how to design a practical and comprehensive checklist for use by mental health and medical practitioners that would make it easier to accurately diagnose anorexia nervosa in males. This question was addressed by the literature review, interviews with Master's level Counselor Education graduate students, a pilot survey, and interviews with medical and mental health professionals using the AANMQ.

Assumptions

This research on male anorexia relied on three assumptions:

1. For many in the counseling and medical professions, the characteristics of the male anorexic are unclear or are unknown.
2. Many males are misdiagnosed or are underdiagnosed with anorexia nervosa.
3. The DSM-IV is the most widely utilized tool by mental heath and medical practitioners for the assessment and diagnosis of anorexia nervosa.

Delimitations

The researcher chose to impose several factors in which to delimit this study. These factors were purposely selected by the researcher as a means of establishing boundaries to the study and included the following:

1. The researcher selected a panel of experts from a variety of disciplines to interview based on their experience and knowledge of male anorexia.

2. The profile and description of a male anorexic was derived from the panel and the literature. This was decided upon due to the limited accessibility of a male anorexic and the confines of confidentiality in the professional counselor-client relationship.

Limitations

As a result of the delimits set for this study, there are specifics limitations which must be considered, especially in terms of their ability to impact generalizability of the results. These include:

1. Because of the small sample size of the expert panel, results must be cautiously generalized to other inpatient, outpatient, day treatment, private practice, or mental health settings.
2. Behavior and profile of the male anorexic was assessed retrospectively by the panel and may have affected the accuracy of the information provided.

Definitions

The following operational definitions are relevant to this study:

Amenorrhea - the cessation of menstrual discharge that typically accompanies anorexia nervosa.

Anorexia Nervosa - the essential features of anorexia nervosa are that the individual refuses to maintain normal body weight, is intensely afraid of gaining weight, and exhibits a significant disturbance in the perception of the shape or size of his or her body. In addition, post menarcheal females with this disorder are amenorrheic (APA, 1994).

Antidepressants - a class of drugs used for the treatment of depression.

Client - an individual who willingly enters into a facilitative relationship with a mental health professional seeking emotional growth and change.

Day Treatment - a treatment program designed for attendance during the day. It is designed and structured like an inpatient program with the exception of the client/patient returning home for the evening.

Dieting - an intentional restriction of food intake for the purpose of losing weight.

Disease - a deviation from physical or mental health used interchangeably in this study with the word disorder.

Disorder - a disturbance in an individual's physical or mental health.

Expert Panel - a group of mental health and medical practitioners who are licensed in their disciplines, have five years experience in their field, and have worked with at least two male anorexics.

Inpatient - an individual hospitalized for medical or psychiatric treatment.

Libido - sexual energy.

Male - an individual possessing both an X and Y sex chromosome and who identifies himself as male based on his adoption of the male sex role.

Neuroleptic Drugs - (also known as anti-psychotics) a class of drugs used to reduce and/or control delusional thinking and alterations in mood.

Outpatient - an individual receiving medical or psychiatric services in a therapeutic environment. In this setting, the patient has the option to determine the delivery and time of services.

Patient - a person receiving medical or mental health treatment.

Selective Serotonin Reuptake Inhibitors (SSRIs) - A class of antidepressant drugs used primarily for the treatment of depression.

Treatment - a plan designed to promote weight restoration, and decrease distorted and delusional thinking in the client through medical or mental health interventions.

Need for the Study

Eating disorders are associated with a number of psychological and medical concerns that can range from mildly problematic to fatal. There are a number of reported estimates regarding the incidence of death and anorexia with a figure of 5% most often cited in the literature. However, most of these figures are based on female samples and include death by suicide as well as emaciation. Other problems associated with self-starvation include, but are not limited to: Cardiac irregularities and dysrhythymia which can result in sudden death; dehydration; electrolyte imbalances resulting in severe bloating, edema, and muscle spasms; vitamin and mineral deficiencies; organ dysfunction resulting in bowel and kidney difficulties; osteoporosis; tooth decay; and hormonal imbalances as evidenced by lowered testosterone levels in men and amenorrhea in women. Anderson (1990) remarks that if one can understand the nature, course, and treatment of eating disorders, then one will also understand most of the field of psychiatry, cultural issues, and internal medicine as these disorders impact every organ system of the body as well as one's personal and interpersonal life.

In 1994 the National Association of Anorexia and Associated Disorders (ANAD) reported there were 7 million females and 1 million males in the United States who had an eating disorder. Anorexia Nervosa and Related Eating Disorders, Inc. (ANRED) states that while there are no solid statistical figures, it is believed that about 5% to 10% of the total number of people

with anorexia nervosa are male. Arbetter (1994) offers a slightly more conservative figure suggesting that eating disorders in general affect 2 million females between the ages of 12-18 years and half a million males yearly. All of these figures must be viewed with caution, as it is likely that this is a disorder that is underreported and misdiagnosed in the male population. It is important to note that even if only 5 or 10 percent of the individuals who are diagnosed with this disorder are males, this still accounts for a tremendous number of people. Dorian and Garfinkel (1999) state:

> Anorexia nervosa and bulimia nervosa have been considered to be influenced by cultural forces; as these forces change, the disorders themselves may be altered. Such changes could affect the rates of the disorders, the ages of onset, the global characteristics of the disorders, or the particular syndromal characteristics of the disorders. Awareness of the impact of sociocultural forces is critical to enhancing the understanding the etiology and pathogenesis, and to informing models of care (p. 187).

Adults, adolescents, and an increasingly larger number of children, are obsessed with body image and how they appear to others. Paxton et al. (1991) found that dissatisfaction with body image is common during the teenage years and that excessive exercise is a frequent behavior among adolescent males as a means of losing weight, whereas dieting behavior tends to be more prominent in adolescent females. Research has demonstrated that for females, the images dictated by culture regarding ideal beauty through magazines, films, television, beauty pageants, and even dolls, such as Barbie, can trigger an obsession with weight and consequently, an eating disorder. However, females are not the only ones whose body images are affected by the media. Pope (1999) discusses the changing physiques of male action figures over the last 10

years and how these “muscle-bound play figures” may be a contributing factor in the growing problem of body image disturbance in males. It is critical then, that counselors, educators, public health, and medical personnel become acquainted with the skills necessary to better identify, treat, and prevent anorexia nervosa in both males and females.

Many questions exist regarding males and eating disorders since the majority of research has been conducted with females and then generalized to males. Davis (in O’Hehir, 1999) states “Male patients feel that their disorder is an anomaly. For women, it’s a common disorder, however anguishing. Men have to get through being terribly ashamed of having an eating disorder to begin with – they often see themselves as freaks” (p. 104).

In addition to seeing the frequency of eating disorders among males develop, a second disturbing trend also appears to have emerged; that is, a preoccupation with weight issues at increasingly earlier ages. In Frances Berg’s 1997 book Afraid to Eat, she cites an Ohio study regarding weight preoccupation and body dissatisfaction. The findings revealed that of the children researched in grades 1 through 5, 40% of the girls and 25% of the boys reported trying to lose weight. Not surprisingly, the study found that girls who were dieting seemed more distressed about their body shape than non-dieting girls as did dieting boys compared to their non-dieting peers. The children trying to lose weight tended to be heavier at the onset, had lower self-esteem, and greater levels of dissatisfaction with their weight than children with no history trying to lose weight. Berg also reports that in a study conducted on a group of 5th graders by researchers at the University of South Carolina, 40% of the children felt too fat or wanted to lose weight even though 80% were not overweight. They also found children as young as 9 years old with severe eating disorders, including anorexia nervosa and bulimia nervosa.

Berg discusses the urgency for both media and public health officials to become more concerned with eating disorders, particularly anorexia nervosa. Individuals who are engaged in excessive dieting are depriving themselves of important nutrients such as calcium and iron which can affect long-term health problems related to physical growth and the development of mental problems such as depression, confusion, hysteria, psychosis, and eventual death by starvation. Excluding parents and teachers, counselors working in both educational and mental health settings are the first to interact with these children. It is essential that counselors become aware of the characteristics associated with anorexia nervosa in both females and males as well as treatment methods that can be applied when working with this population.

Little reference appears to be given in academic training programs regarding male eating disorders and virtually no acknowledgment is given in texts. Aspiring counselors, clinicians, nutritionists, and professionals in related disciplines remain uninformed and will seldom consider anorexia nervosa or other eating disorders as possible diagnoses for males, even when these distressed individuals present with the majority of the indicators listed in the DSM-IV. This is unfortunate as one male anorexic laments, "Although concern about anorexia is growing, there is still a large unawareness, especially about male anorexia…My parents and I could not pick up a book and read about male anorexics. For all we knew, I was the only man in the world with anorexia" (Krasnow, 1996, p. 24).

Organization of the Study

The remainder of this dissertation is organized as follows: Chapter Two contains a review of literature related to anorexia nervosa in males and characteristics associated with this disorder. Chapter Three details the research design, research participants, and a description of the

instrument, Assessment of Anorexia Nervosa in Males Questionnaire used in data collection and analysis for this study. Chapter Four presents results of the study. Chapter Five discusses results, presents conclusions and implications, and provides recommendations.

CHAPTER TWO

Literature Review

This chapter presents a review of literature that is germane to this study of males and anorexia nervosa. It is outlined in the following manner: First, the existing literature is examined in regard to problems associated with anorexia nervosa. Second, prevalence of anorexia nervosa and males is described. Third, the characteristics of male anorexics are presented. Fourth, research studies that have been conducted with anorexic males are introduced. Fifth, the media and how it impacts anorexia nervosa is reviewed. Sixth, sexuality and anorexic males are discussed. Seventh, anorexia nervosa among athletes is examined.

Problems Associated With Anorexia Nervosa

Over the past two decades, a greater understanding of the long-term course of anorexia nervosa has emerged. Research reveals mortality rates as high as 20% with many of these deaths resulting from cardiac failure or suicide (Bowers & Anderson, 1994-1995). As anorexia nervosa is a complicated blend of physical and emotional elements, attention must be directed to both the course of diagnosis and treatment. Interestingly, even though the anorexic is malnourished and to others appears emaciated this does not hinder his or her food intake and self-perceived body image as "normal." Anorexics truly believe their restricted food intake is sufficient and seldom see themselves as starved because they do eat and what they eat is healthy. The problem is they eat only limited amounts, resulting in inadequate caloric intake (Mickley, 1994). As a result of this limited nutrition, serious health problems arise which affect both the physical and emotional well being of the anorexic. Mickley (1994) states that individuals with anorexia nervosa become plagued with thoughts of food and weight. These persons experience depression, fatigue, heart

problems, insomnia, body temperature problems in that they always feel cold, complain of feeling bloated, constipation, and may begin to grow fine body hair or lanugo. Many anorexics minimize and mask these symptoms and continue to engage in their regular activities and routines. It is not until they become extremely emaciated or experience a severe health problem that family and friends become aware of the severe weight loss. It is at this point that the anorexic is transitioned from a person who is "dieting" to a person who is "potentially dying" from anorexia nervosa.

Current literature is saturated with numerous explanations, causes, treatments, and preventions of anorexia nervosa. Despite voluminous articles, papers, and books written on this topic, very little mention is ever made to males with eating disorders and specifically references to males with anorexia nervosa. Hsu (1990) contends that eating disorders are seldom diagnosed in males because they are assumed to be a female disorder and that in general, few males appear to be bothered by weight issues. Males are also more capable of disguising their weight loss due to the manner in which they dress. Arbetter (1994) illustrates the shame and reluctance of males to admit to eating disordered behavior as she discusses a male college student who at 6 feet 2 inches weighed only 100 pounds. The student reported that rather than admit to having anorexia, he told people he was being treated for depression as "it sounded more manly." Carlat et al. (1997) contend that in the past 300 years since anorexia nervosa was first described, there continues to be very little written regarding males and eating disorders and that the majority of the research has been limited to case reports or case-control studies. They also suggest the need for additional research in this area for both diagnostic and treatment decisions.

There is an increasing interest in anorexia nervosa among males with reports suggesting the disorder is escalating at an alarming rate. Pope (1999) discusses the expansion of literature

regarding body image disturbance among males and how it is frequently associated with eating disorders in the male population. He reports one study found a strong similarity between college men and women and their levels of body dissatisfaction. Braun, Sunday, Huang, and Halmi (1999) state while eating disorders are less common in males (generally accounting for 5-10% of anorexics), the percentage of males admitted to the eating disorder unit of The New York Hospital-Cornell Medical Center, Westchester Division, has increased from 1984 to 1997. They suggest if males begin to feel a greater comfort with seeking treatment due to heightened publicity of eating disorders being a disease that strikes both genders, then this may result in a surge in the number of males to seek treatment. Consequently, it may allow mental health and medical professionals to become better able to detect eating disorders in males and refer them for treatment.

Prevalence of Anorexia Nervosa and Males

Current figures regarding the prevalence of anorexia nervosa among males indicate it is approximately one-tenth as common as it is in females (Alexander-Mott, 1994; Hsu, 1990; Margo, 1987). Crisp (1996) believes this is too high. Rather, he contends that it is closer to 2% at the most. One reason for this discrepancy may be due to the DSM-IV definition. While the definition is adequate for diagnosing females, it does not clearly define symptomology that is present in males. Anderson (1990) states, “The diagnosis of males with eating disorders is usually a straightforward process, but as with appendicitis, you have to first think of it as a possibility” (p. 133). He further remarks that one of the hallmark features used to diagnose anorexia is amenorrhea but that “there is no analogous criteria for males…abnormal reproductive hormone function in males can be well documented and should be a requirement for noting the

diagnosis just as for females" (Anderson, 1993). Braun (1997) also suggests that while amenorrhea is recognized as a major diagnostic indicator for anorexia nervosa in females, no similar criterion exist for males. O'Hehir (1999) further supports this belief by stating "…amenorrhea …was regarded for years as a central criterion of anorexia-men, by definition couldn't have it" (p. 104). This diagnostic feature, therefore, may be one reason for the under-recognition of the disease in males. Men do not experience amenorrhea, which is one of the crucial signals that alerts a counselor or medical professional to consider a diagnosis of anorexia nervosa. Instead the endocrine disturbance they encounter is a general decline in the levels of testosterone production which results in diminished sexual desire and performance (Carlat et al., 1997; Herzog, Bradburn, & Newman, 1990). One of the more notable indicators used to diagnose anorexia nervosa as outlined by the DSM-IV (1994) is the presence of amenorrhea in females but no parallel criterion is mentioned for males. This suggests that there is possible gender bias in the terminology used for diagnostic purposes. Furthermore, it is likely to influence the professional's interpretation of this being a disease or disorder that affects only females. Males do experience endocrine disturbances when they engage in self-starvation and excessive exercise as evidenced by a lowered testosterone level. This is difficult to assess in an interview setting with adolescents, however, due to the wide range of hormonal production at this age. Also, it is unlikely that the counselor will receive an honest response (at least initially) to questions that are related to sexual drive or interest. Additionally, there appears to be a discrepancy in mental health and medical providers understanding of the prevalence, etiology, and central features that are associated with eating disorders (Hsu, 1990). This lack of agreement may also hamper the recognition of males and eating disorders.

Another component that may lead to inappropriate diagnostic decisions and confusion regarding anorexia nervosa is the notion of food aversion or food phobia. The DSM-IV does not include this as a differential diagnosis. Individuals occasionally present to a mental health or medical practitioner with eating disturbances and may be improperly assessed and diagnosed with anorexia nervosa on Axis I, when in fact they are experiencing an anorexia that should be diagnosed on AXIS III. Indeed, it is not unusual for children or adolescents to experience poor appetites or develop aversions to certain foods. Siegel (1982) states that the incidence of eating problems in young children has been reported to be as high as 45% but that these are problems that most will outgrow. There is however, a subgroup that does engage in anorexic-like eating behavior, and it is important to note that while these two behaviors may appear outwardly similar to the clinician, they may in fact be quite different and evolved from very different physiological and psychological arenas. Unlike anorexia nervosa, food aversion may result from a medical problem. Consider that the medical disorder or the intervention used for medical treatment may be incompatible with eating. Ingesting food may cause abdominal pain, vomiting, diarrhea, or any number of unpleasant symptoms. Therefore, the individual may actually train him or herself not to eat (especially solid foods) for fear of deleterious consequences (Stark, et al.1993). This learned behavior to avoid eating is more readily assessed with inquiries regarding when and how the avoidance of foods emerged. Unlike the anorexic, this client is likely to be more compliant, provide a more comprehensive developmental history, and respond successfully to nutritional interventions and behavioral procedures (Siegel, 1982; Stark, et al., 1993).

Colton, Rodin, Olmsted, and Daneman (1999) suggest certain chronic medical conditions may also place individuals at risk for developing eating disturbances, particularly ones that require patients to monitor their food intake and blood sugar levels, as in diabetes mellitus (DM).

As a means of controlling DM, the patient is required to engage in consistent eating patterns, control carbohydrate intake, and maintain precise measurements of insulin dosages. As this is already a group who may be perceived as treatment-resistant, adding an eating disorder to the mix can render serious complications such as diabetic retinopathy, nerve damage, and ketoacidosis, which can lead to a coma and possible death. Colton et al. (1999) state that individuals with DM are occasionally encouraged to ignore their hunger cues and eat according to externally determined cues and criteria. If an individual has difficulty identifying internal cues and is taught to rely on predetermined meals, further dietary dysfunction may occur and result in disordered eating. They further report 45% to 80% of adolescent girls with DM admit to binge eating, and 13% to 36% regularly omit or decrease their prescribed insulin dose in attempts to control their weight. These figures are rather disturbing when one considers the ongoing education a diabetic patient receives from physicians, nurses, and dieticians not to mention the consequences that occur if one does not maintain appropriate blood sugar control.

Research Studies on Anorexic Males

Keel, Fulkerson, and Leon (1997) report their search of the literature revealed no studies of eating disorders in early adolescent males and that, to date, much research on predictors of eating disorders have been based on female samples. These findings therefore, may not generalize to males. In fact, there may be other factors that are at play in predicting poor body image, low self-esteem, and resulting eating disorders in males. It is essential to determine the existence of any gender differences that might be affecting body image as a means of providing more appropriate prevention and intervention in this population. DeAngelis (1997) reports there are no reliable prevalence studies that have been conducted on men with eating disorders, but

that clinical estimates suggest 1 out of 10 patients with anorexia or bulimia are male. Kinzl, Mangweth, Traweger, and Biebl (1997) lament the lack of studies performed with males and state they could find nothing that examined the impact of adverse childhood experiences on disordered eating in males yet studies that investigated this correlation among the female population were plentiful.

Keel et al. (1997) suggest how boys feel about their bodies can influence their engaging in eating disorders but the factors that may determine this are still unknown as the variables used in their research to study disordered eating precursors were determined by previous research based on females.

Characteristics of the Male Anorexic

Halperin (1996) suggests unlike girls, boys form an image of their body from participation in sports as the socialization of a team activity reinforces an outside source of acceptance of their body. Kearney-Cooke and Steichen-Asch (1990) in their study of male body image and eating disorders found that from birth, boys become indoctrinated with what it means to be a man. They hold the belief that this entails a certain set of attitudes and behaviors that exude independence, a preoccupation with career, competitiveness, physical strength, aggressiveness, and courage. When the young male has difficulty obtaining these goals, emotional isolation occurs which results in problematic behavior. There are a number of similarities in males and females with eating disorders but as Halperin (1996) states, there is no conclusion in how they are related to one another. It is believed that females diet excessively to lose weight, whereas males are more likely to engage in excessive exercise as their major method for losing weight. Research has demonstrated that males with eating disorders exhibit a

psychological profile that is analogous to females with eating disorders, encompassing both a sense of interpersonal ineffectiveness and an inability to control their emotions (DeAngelis, 1997). Anderson (1995) reports that while the disorders may appear the same for both males and females, the course for getting there is quite different. “When individuals are very ill, suffering from emaciation or abnormal electrolytes and other medical complications, they appear very similar and require similar treatment…but as patients become medically healthy and the symptoms are deconstructed, the individual life story behind each patient unfolds to reveal differences between the sexes in predisposition, course, and onset” (p. 1).

Anderson (1992) suggests that males who develop eating disorders differ from females in three major areas of dieting behaviors. The first involves why males diet. He contends that in contrast to females, who diet because they feel fat, males diet because they have been overweight at some point in their lives. Secondly, males more often than females diet to attain certain goals in sports or to avoid some type of sports-related injury that would be related to a weight gain. Thirdly, there is a greater preponderance of men who diet to avoid potential medical problems, especially ones they may have seen develop in their parents. Issues of self-esteem are different for the male too. They may think that dieting and exercise will allow them to feel more masculine and therefore, more in control which in turn will lead to greater respect from those around them (Anderson, 1992). A higher incidence of homosexuality or gender-identity confusion has also been reported among males with disordered eating patterns with estimates as high as 21% of affected males being homosexual (Anderson, 1990; Braun & Crisp, 1980). Kearney-Cooke and Steichen-Asche (1990) offer that males with eating disorders tend to have close relationships with their mothers and are more likely to have experienced ridicule from their peers in response to their physical appearance.

The Impact of Media on the Development of Anorexia Nervosa

It is believed that both males and females have become more body conscious in recent years with the fashion industry being the primary force behind this preoccupation. Crisp (1996) disputes this, reporting his studies found teenage girls are just as concerned with appearance, body shape and size and as they were 20 years ago. In contrast, few adolescent males reported anxiety about these issues 20 to 25 years ago. Currently those who do express body image concerns are likely to be overweight, growing rapidly, or in a state of gender identity doubt. Research is consistently finding that while men may be less subject to the factors that motivate women toward eating disorders, they are not immune as once believed to the media and the powerful influence it plays in the development of eating disorders and the underlying psychopathology that accompanies this behavior (Kearney-Cooke & Steichen-Asch, 1990).

The media play an important role in how we define ourselves and what is perceived as the "ideal" for both men and women. Males as well as females are exposed to distorted and destructive definitions of perfection. For males, the popular ideal has accentuated superior physical strength and athletic prowess (Kearney-Cooke & Steichen-Asch, 1990.)

Dittrich (1998) reports that the average person sees between 400-600 advertisements per day, or approximately 40 to 50 million by the time he or she reaches the age of 60 years. One out of 11 of these advertisements contain a direct message of beauty. Often an impossible or unattainable image is projected and we clamor to copy it through exercise, diet, or cosmetic surgery. Magazine covers portray absolute perfection and inform us how we too can obtain this look. They fail to mention, however, that the Adonis or Goddess is often a composite, or a computer generated image of several people, or that the beauty we hope to replicate has been air-brushed and perfected prior to publication. Magazines and self-help books inform us to love

ourselves (warts and all) and then in absolute contradiction suggest we lose weight, change our diet, improve our personal appearance, and use models as young as 13 years old to demonstrate how we can look like these young beauties if we adhere to a stricter sense of self-discipline and self-love. Is it any wonder that eating disorders are rampant in our society and are affecting all groups of people? What was once considered a middle-to-upper class, white girl's disease has crossed over to the male population as well as claiming a growing number of Hispanic, African-American, Asian, and Native American victims. Eating disorders are now reported to be one of the most common psychological problems among young women in Tokyo, Japan. In Argentina, the number of individuals with anorexia nervosa and bulimia is documented to be approximately three times greater than that of the United States. Eating disorders are on the rise in China as well, with several theories abounding as to why (Something Fishy Website, 1999). Dittrich (1998) writes, "The more a person is pressured to emulate the mainstream image, the more the desire to be thin is adopted, and with it an increased risk for the development of body image dissatisfaction and eating disorders" (p. 1).

Despite the growing number of victims who fall prey to anorexia nervosa and other eating disorders, recognition is still given primarily to the young, white female. Perhaps the media are responsible for this as well. Empirically based and clinical research studies have suggested that males comprise on the average, 10% (1 male to slightly more than 10 females) of reported cases of anorexia nervosa (Anderson & DiDomenico, 1992; Braun, et al., 1999). Interestingly this figure corresponds to the number of diet articles and advertisements in magazines read most frequently by young females as opposed to a predominance of shape articles and advertisements in magazines read by males. This 10 to 1 ratio of diet articles in magazines corresponds perfectly with the documented ratio of females to males having eating

disorders, in both the general population and in referrals to treatment centers. This intimates that the sociocultural norms that promote thinness may also be an important part of the onset of eating disorders (Anderson & DiDomenico, 1992).

In addition to the various advertisements, articles in popular magazines regularly discuss the horrors that young girls face as they mature into adulthood and are assaulted with idealistic images and the desire for perfection. This is personified by a preoccupation with Hollywood and the tabloid magazines that cater to this masquerade. Starlets who appear extremely thin are at first glorified then vilified with rumors of anorexia. A double standard emerges: When their male counterparts are visibly emaciated the headlines not only ignore anorexia nervosa, but focus on something such as AIDS or cancer. In an article entitled "Out of Control" (People Magazine, 1999) it was reported that since 1983 "the numbers of women seeking treatment for eating disorders has skyrocketed" (p. 52). Marcia Herrin, the codirector of Dartmouth College Eating Disorders Education, Prevention, and Treatment Program is quoted in the article as saying, "Sufferers -- 5-10 million females and 1 million males--tend to be young (from 14-25), white, affluent, perfectionistic, type-A personalities" (p. 52). Despite these statistics, and the alarming number of males reported having an eating disorder, the article focuses only on females. This is yet another example of the exclusion and discrimination that males face in regards to equal billing for acknowledgment of anorexia nervosa and eating disorders in general. This is what the typical American is reading and, therefore, the information on this disorder is not being sufficiently relayed. As mentioned earlier, the media, namely magazines such as People and Newsweek have a powerful impact on everyone including laypersons and mental health professionals who not only receive formal education but also get their information about anorexia while standing in the grocery line.

The literature suggests that concerns with body image among males tend to center on looking masculine, i.e., muscular as well as thin in response to the sexualized advertisements that are constantly flaunting the ideal body shape and size. Diagnosing eating disorders in males may be further complicated due to the terms used to define their concerns regarding body shape and how they differ from the terminology used by females. Cultural pressures greatly impact body image and the induction into eating disordered behavior. Traditionally, females have had greater pressure placed on them by the media to look a certain way and are positively reinforced for being thin. Current research however, demonstrates that more men are beginning to worry about their body shape than ever before. A number of factors are believed to be responsible for this phenomenon. Perhaps the most critical is the increasing number of advertisements that reflect body image concerns for males and females (DeAngelis, 1997; Marx, 1994; Mickalide, 1990). Anderson (1990) reports males seldom express distress over the amount they weigh or the size of their clothes. Instead, they appear to be more worried about perceived malformations of their bodies and a desire to obtain the more classic "Adonis" shape. He further states, "We have not observed in males anything comparable to the psychological trauma some women suffer in going from a size 3 to a size 5, for example, or the overinvestment in a certain number of pounds, like staying in the double digits in weight, below 100 pounds" (p. 137). DeAngelis (1997) references James Rosen, Ph.D., a professor of psychology at the University of Vermont who argues 'If you take all kinds of appearance preoccupations--including the desire to be bigger and weigh more, concerns about hair, nose, skin, and other parts of the body--you'll find many more men have body-image problems than you'd think.' Certainly, one cannot deny the value society places on being attractive and thin and while this is a guideline that is applied

more stringently to women, it is becoming increasingly important to both genders and that satisfaction with one's body is highly correlated with self-esteem (Siever, 1994).

The sexual objectification of males has become more evident as witnessed by the increased images of a toned and muscular male model with his washboard abdominals beckoning us to buy any number of products (Siever, 1994). Additionally, the recent trend in fashion and health magazines for men along with the use of men in advertisements to sell merchandise has resulted in more males beginning to develop problems that have generally been associated with females, i.e., body image disturbances and eating disorders. Indeed, advertisements aimed at consumers are powerful and extremely influential. Potter (1998) discusses one male who reported being motivated by a Hanes underwear advertisement to work out for longer periods of time in order to obtain that "buffed" appearance. Peter Arnell of the New York advertising agency the Arnell Group, states that the male torso reigns as the decade's most powerful crossover image appealing to men, women, gays, and straights (Potter, 1998). As a result, now more than ever, looks count! Kearney-Cooke and Steichen-Asch (1990) report that non-eating disordered males prefer a V-shape physique whereas those men with eating disorders strive for a "lean, toned, thin" shape. Overall, it appears that the two most desirable physiques are a slender, feminine body type or a more pumped-up, low-fat shape, both of which are difficult for the average male to acquire. Harris, (as cited by Potter, 1998) suggests that these two body images have evolved from the gay community and that AIDS has heavily influenced this trend of a slender, muscled, low-fat body. Recognizing the appeal of these body physiques, Madison Avenue has exploited and popularized them to sell any number of products from underwear to Diet Coke. To achieve either ideal, body-conscious males of all ages have begun to engage in dangerous behaviors that have been typically seen as female. These include:

excessive exercise, ingesting diet and protein supplements, engaging in unusual dieting behaviors, and resorting to steroid use, with teenage boys being the new at-risk category for developing eating disorders (Potter, 1998). Carlat et al. (1997) suggest that homosexual males are similar to females in that they tend to be more concerned with their body weight and size which increases their vulnerability to developing an eating disorder. They report in their research on eating disorders among males, 5 out of 135 homosexual men, stated that their eating disorders developed in response to the pressure from the gay subculture to be thin. This is in contrast to the heterosexual anorexic male who appears to be more concerned with body shape and muscle definition. Lemberg (1992) states that there seems to be some evidence suggesting more issues in sexual identity associated with teenage onset of eating disorders, whereas later life onset seems to be associated with issues such as marital and work-related conflicts. As gay males are perceived to be more susceptible to an eating disorder, this may cause an additional problem to the individual who is struggling with eating disordered behavior. The male may now question his sexuality as he fears being labeled as having a “gay male” or a “female" disorder. As a result, he may be less likely to seek professional attention for his problem.

Sexuality in Males with Anorexia Nervosa

There appears to be a stereotype of the typical male anorexic. This profile generally embraces the image of an effeminate, homosexual male model, actor, or dancer. There have been studies that indicate homosexual men, like women, experience similar pressures to maintain a thin and youthful appearance (Herzog, Bradburn, & Newman, 1990; Siever, 1994), but researchers have also suggested many men with eating disorders are heterosexual. Anderson (in O’Hehir, 1999, p. 194) alleges, “Gayness increases the risk for anorexia because the gay

community places a higher value on slimness and on attractive body shape, but it is still 80% a hetero guys' disease." Estimates regarding a firmly established gay orientation among males in the general population range from 3% to 5%. When this figure is contrasted to the 20% of males diagnosed with eating disorders as being homosexual, a gay orientation in males does appear to be a risk factor for the development of eating disturbed behavior (Anderson, 1999).

Carlat et al. (1997) suggest that surveys of homosexual men have shown this population is inclined to be more unhappy with their body weight and shape than their heterosexual peers and they believe like females, that their physical appearance is of primary importance to their sense of self. These opinions than, may increase their vulnerability to the development of an eating disorder. It is important to note that when attempting to determine a male's sexual orientation and the predisposition to an eating disorder, one must consider the often small representation of males used in research studies. Many findings to date suggest that homosexuality is common in males with eating disorders, but clinical samples may underrepresent heterosexual men as they are likely to be reluctant to seek help for what is popularly perceived as a female disorder (Herzog, et al., 1990). Brand, Rothblum, and Solomon (1992) in a study measuring restrained eating among lesbians, gay men, and heterosexuals, found weight was of greater concern for women than for men, regardless of sexual orientation. Additionally, the women expressed a greater preoccupation with dieting and had a greater dislike of their bodies than their male peers. They contend that their study lends further support to the hypothesis that heterosexual women and gay men are more affected by societal norms about weight than are lesbians and heterosexual men. Interestingly, they also report that men regardless of sexual orientation are more likely to be more sexually attracted to other people based on their weight. Siever (1994) reports similar findings and states that gay men demonstrate a high

concern for both their own physical appearance as well as that of their male partners. Interestingly, he also found that gay men, who view their bodies as sex objects in which to attract other males, were more likely to experience dissatisfaction with their bodies. Like their heterosexual male peers, they express concern about physical strength, and like heterosexual females, worry about physical attractiveness. These two variables therefore, heighten the vulnerability or risk of developing an eating disorder among gay males.

Anderson (1999) suggests there are significant stigmas that surround males with eating disorders and reports one HIV-positive gay male with bulimia who believed his eating disorder was more stigmatizing than his HIV-positive status. When one considers the manner in which HIV-positive individuals are ostracized and discriminated against in our society, then this statement is truly sobering. The stigmas Anderson (1999, p. 209) believes eating disordered males encounter are:

- Self-Stigma: “girl’s disease,” “gay guy’s disease”
- Societal stigma: “girl’s disease,” “gay guy’s disease”
- Professional stigma: diagnostic bias or ignorance
- Stigma from females who have eating disorders: males are “poachers” on the their illness or become transference objects
- Stigma from treatment programs: rejection from many programs (“We can’t/don’t treat males.)
- Stigma from health maintenance organizations: “males do not have anorexia, so we will not pay for treatment”

With so much stacked against him at virtually every level of intervention, (from assessment to treatment to prevention) it is not unusual to hear the male anorexic report feelings of humiliation,

shame, and alienation. These emotions therefore, are likely to interfere with him seeking treatment or being totally honest with his mental health or medical professional.

Anorexia Nervosa Among Male Athletics

In the last decade, an interest in exploring the variables that may clarify gender differences in regards to body image and eating disorder disturbances have emerged (McDonald, & Thompson, 1992). Until recently, males have appeared to be insulated from the development of eating disorders and specifically, anorexia nervosa. In males as in females, eating disorders frequently occur in athletes and especially in sports that demand weight control. Davis (1999) remarks that participation in routine exercise, especially aerobics and weight training has been linked to body dissatisfaction and a tendency to diet, which in turn may lead to eating disordered behaviors. Both male and female athletes are using unhealthy and potentially life-threatening weight control techniques, which encourages their induction into eating disorders. These include restrained eating or severe dieting, vomiting, laxatives, diuretics, and diet pills. Athletes, who participate in sports that require leanness such as gymnastics, diving, figure skating, marathon running, ballet, wrestling, and bodybuilding however, more commonly use these methods. Additionally, the emphasis placed on competitiveness and individual performance along with certain personality characteristics such as perfectionism and persistence, traits which enable the athlete to be successful in sports, may also encourage him or her to engage in eating disordered behavior (Shisslak & Crago, 1992). Findings also indicate that males and females possess different reasons for exercising and that this too, may impact one's vulnerability to the development of an eating disorder. McDonald and Thompson (1992) suggest that exercising for weight control, body tone, and attractiveness is positively correlated to eating disturbances and

body image dissatisfaction for both genders. Exercising for mood, health, and enjoyment however, is related to higher self-esteem. Exercising for fitness purposes is negatively connected with eating disturbances for males but is positively correlated with self-esteem for this population.

Goldfield, Harper, and Blouin (1998) suggest that an increase in bodybuilding and weightlifting has paralleled sociocultural norms with a mesomophoric build as the ideal male body type and a lean and toned body for the female. They maintain that the prevalence of eating disorders in bodybuilders is difficult to accurately assess due to several factors which include: the absence of large-scale studies with control groups, a lack of standardized inventories using DSM-IV criteria, and a selection bias in the survey research. They also report that severe dieting; a preoccupation with weight and shape; body image disturbance; pathogenic eating attitudes, behavior and weight control practices; and full-blown eating disturbances are relatively common among serious, recreational and competitive bodybuilders. They further discuss how studies have shown a history of anorexia nervosa in male bodybuilders (2.8%) and female bodybuilders (42%) and that 32% of competitive female bodybuilders reported having bulimia nervosa prior to participating in bodybuilding. Furthermore, they attest that individuals with eating disorders are likely to gravitate towards this sport to compensate for their body image disturbances and achieve personal and societal standards of attractiveness.

Research in body image disturbance has revealed a disorder that is referred to as “reverse anorexia” or muscle dysmorphia and appears to be more common among male bodybuilders than their female counterparts (Pope, Katz, & Hudson 1993). As in anorexia nervosa, this disorder is characterized by a perceptual disturbance with the afflicted individual believing they are too small or weak when in fact they are quite strong and muscular. As a result, steroid abuse and

unhealthy eating patterns become common obsessions. Pope (1999) hypothesizes that this disorder may have developed from our culture's increasing fascination with fitness and developing one's body by any means. "The public is exposed daily, in magazines, motion pictures, and other media, to increasingly-and often-unnaturally-muscular male images. Some individuals, responding to these cultural messages, may become predisposed to develop muscle dysmorphia" (p. 66). Interestingly, empirical studies have found a rate higher than expected by chance of male bodybuilders who develop this disorder to have been previously diagnosed with anorexia nervosa. This finding suggests that "bodybuilders may be at greater risk than most men for body dysmorphic symptoms as a whole, and that sociocultural factors at a particular time may determine whether they move in the anorexic or reverse anorexic direction" (Pope, et al., 1993, p. 408).

CHAPTER THREE

Methodology

Methodological Approach

This chapter describes the methodological procedures utilized for this study. It includes a description of the research design, a review of the research questions, the instrumentation used to answer the research questions, data collection and data analysis. There were three research questions.

The first research question was: What are specific characteristics of male anorexia? Several methodologies were employed to answer this question.

A. A literature review was conducted.

B. A pilot survey was developed which was administered to Master's level Counselor Education students to determine what they knew about anorexia nervosa in males and what if any gaps existed in the training they had received for accurate assessment and diagnosis of eating disorders in males.

C. Follow up, informal interviews were conducted with the participants who completed the survey.

D. These interviews resulted in questions not addressed by the survey that needed to be included as well as eliminating and clarifying other content. Findings of the pilot study led to the development of an instrument entitled Assessment of Anorexia Nervosa in Males Questionnaire (AANMQ). This instrument consists of five components: Respondent Information, Assessment and Diagnosis, Treatment, Medications, and Additional Variables. The questionnaire was also used as the basis for conducting

interviews to assess knowledge of male anorexia. It was given to an expert panel composed of mental health and medical professionals, one male anorexic, and one parent all of whom have expertise and knowledge in the area of eating disorders and males. (See section on Expert Panel that follows.) All interviews were conducted by phone or in person with the medical or mental health practitioner, parent, or male anorexic.

The second research question was: How can the DSM-IV definition of anorexia nervosa be broadened to provide a more comprehensive definition that includes males and females? The procedures used for answering the second research question were:

A. A comprehensive literature review.

B. Interviews with an expert panel to identify specific features that would provide the mental health or medical professional clues to consider anorexia nervosa as a possible diagnosis for males.

The third research question was: What items appear necessary for inclusion on an instrument for recognition and accurate assessment of anorexia nervosa in males? This was addressed in a number of ways. The methodologies utilized included:

A. A comprehensive literature review.

B. Discussions with colleagues and Master's level graduate students.

C. A review of information obtained from the interviews and responses from the expert panel on the AANMQ. These responses were examined to determine if any descriptive themes or concepts were present. Recurring responses were noted and clarified with the interviewees prior to including it as an item for the instrument.

Selection Criteria of Expert Panel

Each of the individuals who participated in the study were selected for their knowledge and expertise in the area of male anorexia and were referred to the researcher in several ways:

A. Some were professionals in the local community specializing in eating disorders and were known either professionally or personally by the researcher.

B. Others were referred by a member of the researcher's doctoral committee.

The individuals on the expert panel represented a variety of disciplines which included:

- psychiatrists
- pediatricians
- nurses
- licensed social workers
- licensed psychologists
- licensed professional counselors
- registered dietitians
- parents of male adolescents who were diagnosed as anorexic
- male anorexics

The process for selection as an expert and subsequent inclusion in the study required each mental health or medical professional to be licensed in their respective profession with five years of experience in their field and experience working with at least two male anorexics.

Instrumentation

Assessment of Anorexia Nervosa in Males Questionnaire

The members of the expert panel in this study were interviewed using the Assessment of Anorexia Nervosa in Males Questionnaire (AANMQ). The Human Subjects Review Committee at Virginia Polytechnic Institute and State University reviewed this instrument. It was designed to determine current attitudes and knowledge of males with anorexia nervosa and collected information that pertained to:

A. Respondent's Demographic Information

B. Assessment and Diagnosis

C. Treatment

D. Medications

E. Additional Variables and Comments from the participants

Expert panel members were interviewed using questions from the AANMQ (Appendix B). The content and delivery of the questions were altered as appropriate for the three groups that made up the expert panel (mental health practitioners, medical personnel, parents, and male anorexics); however, the content remained consistent.

A. Respondent Information: To acquire information about the respondent and their professional background, they were asked to:

1. list their professional position
2. list all applicable licenses they held
3. list their experience in working with anorexic clients as well as the gender and ages of the anorexic clients with whom they work
4. how prevalent they perceive anorexia to be among males

5. how often it is likely misdiagnosed

6. if they distinguish medical anorexia from anorexia nervosa

B. Assessment and Diagnosis: To determine how anorexia nervosa is being assessed in males the participants were asked to discuss:

1. how they assess for the disorder

2. what criteria they utilize (e.g., Metropolitan Life Tables, National Center for Health Statistics, Body Mass Index)

3. if the client presents with psychotic thinking

4. how frequently neuroleptic medications are prescribed

5. common co-morbid disorders that they frequently diagnose in the anorexic client

6. identify the incidence of alcohol and drug abuse

7. identify any sexual identity issues the male anorexic may have

8. list the medical complications they typically see in the male anorexic client

C. Treatment: To ascertain the treatment the male anorexic is typically receiving in both hospitalized and non-hospitalized settings, all participants were asked to discuss:

1. the nature of noncompliance with this type client

2. the levels of care provided for the client

3. the average length of hospitalization

4. the therapeutic approach most commonly applied

5. the utilization of support and therapeutic groups

6. the number of groups designed for males only

7. the number of men who participate in groups dominated by female anorexics

8. the impact the male anorexic has in these primarily female dominated groups

D. Medications: To summarize information about clients and the medications they are prescribed, participants were asked:

1. which medications are most frequently prescribed

2. how often medication is prescribed

3. how do the medications correspond with co-morbid disorders

E. Additional Variables and Comments: To assess for additional trends that may be present in the male anorexic population and how they are perceived, participants were asked to:

1. determine if any socioeconomic differences existed between their male and female anorexic clients

2. reveal the involvement of the identified client's family in therapy

3. list additional relevant comments

Expert Interview Format

Interviews

Interviews with experts were a vital part of the research process as they provided valuable information for the design of the instrument for assessing anorexia nervosa in males. The format used in this procedure involved the interviewer speaking by phone or in person to each member

of the expert panel with a request that they respond to all items on the AANMQ. The researcher then guided the interview with a discussion of the topic by reviewing responses with expert panel members and asking specific questions for elaboration.

These questions included: "Do you believe the DSM-IV is gender biased," "Why/Why Not," "What gaps are present in the assessment and diagnosis of anorexia nervosa in males," "What gaps exist in treatment," and "How can counselors provide more appropriate services to the male client?"

Data Analysis

Data collected from this study were analyzed qualitatively. Results from the AANMQ were tallied for each of the 10 participants included in the expert panel with responses grouped into three categories. These included:

- Mental Health (LCSW, LPC, Psychologist)
- Medical (Psychiatrist, Pediatrician, Nurse, Dietician)
- Patient/Family (Male Anorexic, Parent)

The information obtained from these groups were examined for confirmation and/or contradictions of the literature, and differences among the disciplines regarding assessment, diagnostic and treatment issues regarding the male anorexic. Additionally, the data obtained were summarized to answer the three research questions outlined in Chapter 1.

CHAPTER FOUR

Presentation of Results

This study examined two major aspects of anorexia nervosa among males. Specifically it reported uncertainties about characteristics of the male anorexic and the DSM-IV definition of anorexia nervosa being gender biased, both of which have resulted in difficulty with properly assessing and diagnosing this disorder among males. This chapter presents data collected from the Assessment of Anorexia Nervosa In Males Questionnaire (AANMQ) and personal interviews with expert panel members. Documenting and analyzing respondents' beliefs and opinions about males and anorexia nervosa proved valuable for recording how this disorder is perceived by the medical and mental health community. Information gathered was useful in gaining insight into the expert panel's frustration with continuing misdiagnosis and underdiagnosis of a disease that is growing rapidly in one half of the population. Additionally, responses proved fundamental to the development of an instrument for use in school, clinical and medical settings.

Results are organized in terms of three research questions presented in Chapter One. These questions were answered through a review of the extant literature related to anorexia nervosa in males in Chapter Two and data collected from an expert panel. Due to the early investigative nature of this project coupled with a necessity of obtaining data based on people who were intimately familiar with male anorexia, a total of ten members comprised the expert panel. To answer research questions in an efficient and effective manner, responses of participants were collapsed into three categories as follows:

- Medical professionals –Psychiatrist, Registered Nurse (RN), Pediatrician, Dietician (4 persons)

- Mental heath professionals – Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Psychologist (4 persons)
- Patient/family – Male Anorexic, Parent (2 persons)

A school counselor initially was to be included in the panel. However, because those individuals contacted had no awareness of anorexia nervosa in males or experience working with eating disordered males, they were excluded from the panel.

Responses on the AANMQ were tallied and assessed for both similarities and differences across the three groups. Data are presented in terms of these three groups as illustrated in Appendix C. Blank spaces indicate that individuals interviewed reported the information requested as not applicable to his/her experience or involvement with male anorexics.

Question 1

What are specific characteristics of male anorexia?

Chapter Two addressed Question 1 in detail by presenting findings of researchers and contemporary authors who have examined this topic. The question is restated in this chapter with data presented in terms of a summary of the literature review and a summary of the expert panel's responses to Part II, questions 2, 3, 5, 6, 7, 8, & 9 and Part III, questions 1, 2, 3 of the AANMQ. Appendix C presents the grouped responses to the AANMQ.

Literature Summary

Clinical studies involving anorexic males often contain small samples, and they have relied on anecdotal histories for determining features that may distinguish them from female anorexics. These are limitations that may have interfered with obtaining an accurate profile of

the male anorexic. Research to date, however, has made several assumptions in respect to the characteristics of the male anorexic. A literature review reveals that males with eating disturbances present psychological profiles that are quite similar to females, both in terms of possessing a sense of personal ineffectiveness and a need for control (DeAngelis, 1997). Generally, it is believed that males enter into eating disturbed behavior in the same manner as their female counterparts, i.e., through dieting. The critical differences, however, appear to exist in the motivation for dieting among the sexes. As outlined in Chapter Two, Anderson (1992) suggests that males diet because they feel fat or are already overweight, to accomplish a specific sports-related goal and/or to avoid potential medical problems. Secondly, approximately 20% of identified male anorexic patients are reported as having a gay orientation and 58% are reported as being asexual (Anderson, 1999). It is also believed that males, like females, with anorexia nervosa are likely to have additional psychiatric disorders with the more common diagnoses being mood and personality disorders. Studies have found that anorexic males possess a myriad of personality characteristics that include perfectionism, obsessive thinking, passive-aggressive, dependent, and introverted features. Furthermore, male anorexics have been found to experience more sexual anxieties than females. This is likely due to the struggle they face in meeting cultural pressures of obtaining the perfect body, masculinity issues, and gender conflicts. Studies have also reported that males with anorexia nervosa are more prone to excessive exercise and alcohol and drug abuse than their female counterparts.

Expert Panel Responses

Part II, 2: Does the patient present with a distorted body image?

To assess the relationship between current research literature on characteristics of eating disorders in men and first-hand experiences, the expert panel was asked if anorexic males exhibit a distorted body image. Interestingly, both medical and mental health groups believed this was a common feature among all anorexics. However, the patient/ family group did not believe this was a distinguishing trait. The male anorexic that was interviewed stated that at 96 pounds, he believed he "looked good" and had increased his weight by 24 pounds over the past year and several hospitalizations. The panel's responses reinforce the literature, which suggests the greatest impediment to weight gain for the anorexic patient is distorted body image. The anorexic patient possesses a distorted body image, fallaciously believing that the body is fat, when in fact he/she is actually emaciated. As the patient begins to gain weight however, the distortions will begin to subside but they do not totally disappear (Kahm, 1994).

Part II, 3: Is the patient's thinking "psychotic-like" in regards to these distortions?

When the panel was questioned about psychotic thinking related to distortions in body image, there was a consensus among the mental health group that indeed an aura of psychosis and delusional thinking is present which is due to starvation, but once the patient receives nutrition, this begins to dissipate. Within the medical group, only the RN reported psychotic thinking present in the patient. The psychiatrist stated no awareness of this and the pediatrician reported this question was not applicable to him as he treated patients only on a consulting basis for medical reasons and any psychiatric problems were referred back to the psychiatrist. The

patient/family group reported that no psychotic thinking was present before, during, or after treatment.

Part II, 5: What if any co-morbid disorders are most commonly diagnosed in anorexic males?

All three groups agreed that depression is present among anorexics. Both the mental health and medical groups reported personality disorders as common secondary diagnoses, with the most prevalent being borderline, obsessive-compulsive, dependent, and passive aggressive. The psychiatrist interviewed stated that occasionally posttraumatic stress disorder has been present among the male anorexic patients she has treated. The patient/family group included anxiety as another common problem that accompanies disturbed eating behaviors. These responses support current literature, which suggests that eating disorders are seldom a solitary diagnosis. Rather, there will almost always be additional disorders listed on Axes I and II and sometimes Axis III of the DSM-IV (Anderson, 1990). Connors (1996) reports that pathology on Axis II is very common in eating disorders, with some studies suggesting as many as one half to three fourths of patients in their samples possessing a personality disorder. Diagnoses of borderline, obsessive compulsive, avoidant, and dependent personality appear to be the most common.

Part II, 6: What is the incidence of alcohol abuse?

In response to alcohol abuse among male anorexics, differences emerged from the groups based on their professional and personal experiences. The mental health group agreed that alcohol abuse is seldom a problem among anorexics due to the high caloric content of most alcoholic beverages, and therefore, few engage in heavy drinking. Within the medical group, the

RN reiterated this same belief as well as stating that adolescent male anorexics rarely engage in drinking alcohol. The psychiatrist and the dietician both reported a high incidence of alcohol abuse among the patients they have encountered. The pediatrician reported no awareness of heavy alcohol use as a problem with the patients he has treated but expressed he would not be surprised if this was prevalent among the majority of individuals with disordered eating behaviors. The patient/family group stated alcohol abuse was not present.

Part II, 7: What is the incidence of drug abuse?

The researcher encountered mixed responses from the three groups when they were asked to comment on the incidence of drug abuse. As a whole, the mental health group reported drug use is not uncommon among anorexics with marijuana being the primary drug of choice. One LPC indicated amphetamines are occasionally used and one LPC stated that drug use is frequent among bulimics but that anorexics tend to be more judicious in their use of drugs as they do not want to feel out of control. The psychiatrist in the medical group reported that drug abuse is rather high and is used as a means of self-medication. The pediatrician reported this question as not applicable; the RN believed drugs are used by male anorexics but seldom by adolescents; and the dietician reported drug use as fairly common. Members of the patient/family group reported this did not apply to their experience.

Part II, 8: Have your male patients discussed sexual identity issues?

Each participant was asked if sexual identity issues were discussed throughout the course of treatment. The responses were varied with no consensus among or between the individual groups. In the mental health group, the LCSW stated sexual identity issues could sometimes be a

principle topic in the treatment process. She then relayed having one patient whose sexual identity was paramount in therapy because of his desire to have a sex change operation. One LPC reported never inquiring about sexual orientation and one LPC reported she regularly discussed this with her patients as she believes it is a major part of the therapeutic work for the male anorexic. The psychologist also reported discussing this topic with her patients, and believes the male anorexic has conflict with sexual identity, especially if there is a history of sexual abuse in early ages. In the medical group, only the RN reported that she asked the patient questions regarding sexual identity to uncover turmoil that may be contributing to the anorexic behavior. None of the other members in this group reported discussing this topic, although the psychiatrist did state that prior to prescribing any medications, she explains to the patient that while on certain medications, he may experience a decrease in his sexual drive. The patient/family group stated no discussion of this topic at any point in the treatment process.

Part II, 9: What are the most common medical complications involved with the male anorexic?

Inquiry regarding medical complications of the male anorexic found members of the three groups in agreement and confirmed the literature that suggests no differences exist between males and females in this area. Male and female anorexics are susceptible to cardiac and kidney problems, electrolyte imbalances, impaired metabolism, osteoporosis, and gastrointestinal difficulties.

Part III, 1, 2, 3: How common is non-compliance with this patient? How is it manifested? Does the patient present a specific persona in order to be discharged?

The mental health group reported the male anorexic, much like his female counterpart is often a non-compliant patient who denies having a problem, is resistant to treatment, fails to follow-up on outpatient appointments, and is deceptive in his report of what he eats. The medical group was divided in their responses to non-compliance and the manner in which it is displayed. The RN and pediatrician both agreed that the anorexic is seldom an accommodating patient but that this is a recognizable feature of the illness. The psychiatrist and the dietician, however, report that the male anorexic patient is often desperate for treatment and willing to work on his issues. The dietician further remarked that female anorexics are “pleasers” and will “eat their way out of the hospital” only to return again, but male anorexics appear more eager to deal with underlying issues that contribute to the anorexic behavior. The members of the patient/family group reported noncompliance was not applicable to their experience with any treatment staff in either an inpatient or outpatient basis.

Question 2

How can the DSM-IV definition of anorexia nervosa be broadened to provide a more comprehensive definition that includes males and females?

This question was answered through a synopsis of the literature in Chapter Two and by summarizing panel members’ responses to the AANMQ, Part I, questions 6 and 7 and Part V, Additional Comments. Information obtained in the literature review is presented first, followed by the panel’s answers to the AANMQ. Responses were examined to assess the professional, patient, and family’s perceptions of the DSM-IV diagnostic criteria for anorexia nervosa, how it

impacts making an accurate diagnosis of this disorder in males, and treatment gaps that exist for the male anorexic.

Literature Summary

Anorexia nervosa is defined in the DSM-IV (1994) by four major features. These include:

(a) An individual weighing less than 85% of ideal body weight.

(b) An intense fear of weight gain.

(c) A perception of feeling globally overweight or that certain body parts are too fat.

(d) In postmenarcheal females, amenorrhea.

A comprehensive assessment is critical for successful identification and subsequent treatment for anorexia nervosa. However, before this can be accomplished, one must have diagnostic criteria that address both males and females. Currently, the DSM-IV has no analogous endocrine feature for males that corresponds to amenorrhea (item d, above) nor has the description for anorexia nervosa changed significantly from previous diagnostic criteria listed in the earlier editions of the DSM (Bowers & Anderson, 1994-1995). Despite documented case reports of anorexia that date back as far as 1689, anorexia nervosa remains misunderstood and underdiagnosed in males. Hubscher & Craig (1999) offer that historically, this is likely due to clinicians being unfamiliar with this disorder in males and that the diagnostic criteria excluded males by requiring one of the presenting symptoms to be amenhorrea. Krasnow (1996) stated his purpose for writing about his experience as an anorexic was to bring awareness to this disorder in males and the unique issues that males with anorexia nervosa encounter. Data compiled for this study clearly indicates that before one can appropriately address the needs of the male anorexic

one must first consider this as a possible diagnosis. Furthermore, if one relied solely on the DSM-IV as a guide for diagnostic decisions, this disorder would stand a great chance of being completely overlooked among males. Amenorrhea is perhaps the greatest diagnostic indicator the DSM-IV mentions for anorexia nervosa in females, which immediately alerts the professional working with the patient to the possibility of an eating disorder diagnosis (Braun, 1997). The absence of any comparable feature outlined for males may account in part for the underrecognition of this disorder in the male population. There has been considerable evidence that demonstrates anorexia nervosa in males is associated with a decrease in testosterone levels and subsequent decline in libido and sexual interest (Anderson, 1992; Herzog, Bradburn, & Newman, 1990; Russell & Beaumont, 1987). However, "There is no step-like change in endocrine function in the male that triggers the same concern in parents and physicians that amenhorrea (primary or secondary) does in a female" (Anderson, 1990, p.138). To alert clinicians and counselors to the possibility of anorexia in their male patients, testosterone levels must be addressed in the DSM-IV as well as in the initial assessment. As amenhorrea is an indicator of starvation in females; likewise, low testosterone is the closest evidence of the same in males. There is research that suggests an inordinate number of male anorexics have a history of testosterone deficiency. But to date, there is no concrete evidence regarding the impact it has on the development of an eating disorder or if replacement of this hormone will improve weight restoration (Anderson, 1999; Mickalide, 1990).

Shiltz (1998) suggests we live in a culture that views eating disorders as a problem exclusive to females. Consequently, physicians and mental health practitioners are underdiagnosing these disorders in males, which results in the individual becoming quite ill before the disease is acknowledged and treated. Hsu (1990) states that because eating disorders

in general are typically assumed to be female maladies, males are often underdiagnosed or underreported. Therefore, it is essential that we broaden the criteria we utilize for making diagnoses as well as heighten the awareness levels of school counselors, mental health and medical professionals to the seriousness of this problem in males. To accomplish this, it would appear wise to both expand and reconstruct the terms we use to define and diagnose anorexia. Additionally, mental health and medical professionals must acknowledge males have different preoccupations with body image than females and typically do not use terms such as "thin" or "fat" to describe their body shape, choosing instead to define themselves in terms of being "strong" or "weak." Therefore, the professional practitioner would be well informed when assessing for the presence of eating disorders to use descriptors that males more readily identify with (O'Hehir, 1999).

Expert Panel Responses

Part I, 6: How prevalent do you consider males and anorexia nervosa?

To determine what criteria need to be included in the DSM-IV that would allow for more reliable diagnosing of anorexia nervosa, members of the expert panel were asked to speculate on the prevalence of anorexia in males. With the exception of the psychologist, all the members in the mental health group reported that this is a disorder that is underdiagnosed in males but appears to be seen in only 10% or less of the population. The psychologist indicated that anorexia among males is increasing and is likely very common (despite being underdiagnosed) due to an increased interest in body building and an emphasis on exercise, diet, and the need to possess the perfect body which is fueled by the media, recreational, and organized sports. The medical group also had mixed responses with the psychiatrist and pediatrician stating they really

had no idea other than it is uncommon and in less than 10% of the population. The RN hypothesized that it is seen in only 5% of the male population. Interestingly, the dietitian stated she believed this is a common disorder among males, but that it is usually a secondary problem, which results in anorexia being overlooked. The participants in the patient/family group stated they had no idea how common anorexia in males is and provided no further elaboration.

Part I, 7: Do you believe anorexia nervosa is underdiagnosed among males?

When asked if males are underdiagnosed with anorexia nervosa, the panel members furnished a variety of responses, all of which support current literature on this topic. In the mental health group, the LCSW stated one reason for clinicians and physicians missing this diagnosis in males is due to questions surrounding low body fat, especially for athletes. Low body fat is a goal that many individuals struggle to obtain through normal dieting and exercising and unless the male appears emaciated, it is unlikely to stir a clinician's curiosity. One of the LPC's interviewed corroborated this sentiment and added that it is perfectly acceptable for many athletes, especially runners, to look thin. More importantly, they can explain their thinness in terms of their athletic training. The other LPC stated that anorexia is likely underdiagnosed as it is always tied to another disorder. The psychologist offered that it is underdiagnosed in males because mental health and medical personnel are not asking the appropriate questions. Additionally, the DSM-IV provides no guidelines regarding body mass or "bulk" and because male individuals with anorexia are often excessive exercisers, they appear incapable of recognizing when "enough is enough" in regards to their training. Members of the medical group were all in agreement that this is a disorder often misdiagnosed in males and may in part be due to the notion that anorexia is more acceptable in women. Events that may provoke one into

disordered eating such as sexual abuse are more likely to lead the female to treatment, whereas males are more prone to deny that a problem even exists and will eschew therapeutic services. The patient/family group offered no explanations to this question.

Part V. Additional Comments

Is the DSM-IV Gender-Biased? When asked to comment if the DSM-IV is gender-biased everyone in the mental health group with the exception of one LPC responded with a resounding yes. Remarks included that the criteria need to be more straightforward for diagnosing males. Often, they are diagnosed with "Eating Disorder Not Otherwise Specified," a DSM-IV category for disorders of eating that do not meet the full criteria for more prototypal eating disorders. Or, they may simply be diagnosed as having some form of depression. Without a proper diagnosis, treatment and intervention procedures are ineffective and may, in some cases, prove deleterious to the patient. One LPC remarked that there was nothing wrong with the existing criteria and that the clinician just needs to exclude amenorrhea when considering anorexia nervosa as a possible diagnosis for males. The medical group responded similarly with the psychiatrist and RN adding that the DSM-IV criteria make it easier to diagnose females, which results in males being misdiagnosed due to the omission of criteria that address them specifically. The pediatrician had no comment, stating he does not use the DSM-IV. The dietician reported she believed the DSM-IV is gender-biased but it does not concern her as she does not make diagnoses. This question did not apply to the members of the patient/family group and, therefore, they did not respond to it.

Treatment Gaps

With the exception of the dietitian, there was consensus among the panel members regarding treatment gaps for the anorexic male with all agreeing that they exist. Within the mental health group the LCSW reported that groups for males need to be offered. One LPC suggested it would be useful to have treatment facilities for males and enlighten practitioners to the distinct issues males with eating disorders face. Another LPC reported that while gaps are present, there are not enough males to warrant the offering of specialized services. Rather, it would be more beneficial to include them in co-ed groups and encourage their participation. The psychologist offered that it would be ideal to extend services to males to meet their individual needs. In the medical group the psychiatrist questioned if groups for males would be advantageous as the anorexic male appears to be a "loner" and thus unlikely to participate. The pediatrician did not offer any comment or suggestion to this question and the RN stated only that gaps exist but had no suggestions for improving service delivery. The patient/family group provided may interesting comments. The anorexic himself reported many gaps in treatment and that he believed a hospital program designed specifically for males would be a tremendous improvement for therapeutic interventions. He further remarked that clinicians and physicians need to ask the male about his issues and not assume they are the same as the female patient. He also stated that groups should not be co-ed as males have different issues and cannot relate to the things females discuss, like sexual abuse or loss of a period. The family member interviewed in this group agreed with this assessment and added that it is frustrating to see a child who is so ill be overlooked by mental health and medical professionals. A male has different problems than a female and this needs to be acknowledged.

The panel's responses to these questions support the literature, which suggests that treatment gaps do exist between the male and female anorexic patient. One way to remedy this disparity is to first acknowledge the disorder exists in males and then offer specialized services that focus specifically on the male patient.

Question 3

What items appear necessary for inclusion on an instrument for recognition and accurate assessment of anorexia nervosa in males?

To determine what fundamental criteria would be best for an assessment instrument, the review of the literature in Chapter Two and the expert panel's responses to the AANMQ were analyzed. Both of these methods were useful in clarifying the construct of anorexia nervosa in males. Interpretation of the collected data from both the literature review and expert panel allowed a profile of the male anorexic to emerge. The information obtained from both of these sources allowed the researcher to more clearly outline risk factors and indicators present in the anorexic male and thus permit the practitioner to serve as researcher and regard this as a possible psychiatric diagnosis.

Items assimilated for eventual inclusion for the instrument were selected in the following manner:

1. The literature review conducted for this study.
2. Expert panel's responses to the AANMQ.
3. The researcher's assessment of crucial features.

Once an initial pool of items was developed, the researcher consulted panel members for their scrutiny to ensure that essential elements of male anorexia were included and clearly articulated. This process resulted in the Assessment of Male Anorexia Nervosa (AMAN)

instrument (Table 1). The instrument was devised to serve several important assessment functions. They include:

1. Accurately assess male anorexia nervosa and differentiate this from other psychiatric disorders listed in the DSM-IV.
2. Identify personality characteristics associated with male anorexia nervosa.
3. Evaluate feelings and behaviors of a male anorexic.

The primary purpose of using this instrument is that it can be administered in a short amount of time and obtain a full clinical picture. This user-friendly inventory gives the practitioner a comprehensive and precise profile of the male anorexic in addition to highlighting the specific individual characteristics unique to each patient. It is essential that the mental health counselor, school counselor, and medical practitioner directly ask the patient the questions from the instrument rather than have the patient complete it. This is important because it is likely the male patient will underreport or deny his symptoms due to fear, shame, or simply being oblivious to the concept of having anorexia nervosa. Prior to any formal inquiry, rapport must be established because the patient must believe that the practitioner is interested and receptive to his needs and concerns.

Table 1

Assessment of Male Anorexia Nervosa (AMAN) *

Instructions: The following questions outline features and risk factors that are often present in the male anorexic and alert one to making an accurate diagnosis of anorexia nervosa.
It is important to administer each item to the patient and make further inquiry where indicated to obtain a full clinical picture.

Age ________ Current Body Weight ________ Current Height ________

1. Is current weight below 85% of ideal body weight? (Assess by Body Mass Index)
2. Is there an intense fear of weight gain, despite being underweight?

    ____ Is there a concern that a slight weight gain may give rise to uncontrollable poundage?

    ____ Is being thin a central goal? If so, why is it a goal and how is it being accomplished? ____

3. Is there a disturbance in one's evaluation of body weight or shape? _______________
4. Is there body dissatisfaction?

    ____ Is there a preoccupation with certain body parts, especially buttocks, thighs, abdomen, chest, or biceps?

5. Are there any medical problems?

    ____ Headaches

    ____ Chronic diarrhea and/or related gastrointestinal disorders

    ____ Low blood pressure

    ____ Circulatory problems in fingers or toes

____ Cardiac impairments

____ Kidney problems

____ Dental erosion

____ Weak immune system

____ Hormonal changes

____ Swollen glands

____ Scarred knuckles

____ Dry, rough skin

____ Brittle nails

____ Dry, brittle hair

6. List any prescribed or over-the-counter medications used within the past 6 months. ________

7. Are there complaints of sleep disturbance?

____ Insomnia

____ Hypersomnia

____ Fatigue

8. Are there reports of depression?

____ Worthlessness

____ Helplessness

____ Hopelessness

9. Is there loss of appetite? (Typically anorexics do not experience)

If yes, please discuss further. ____

10. Is excessive dieting reported?

    ____ Chaotic eating patterns, unusual food intake

    ____ Limited consumption of food or restrictive food groups, e.g., no carbohydrates

11. Is there a preoccupation with food?

    ____ Dreams about food?

    ____ Inordinate amount of time thinking or reading about food?

    ____ Inordinate amount of time spent planning daily meals?

12. Is the pursuit of thinness or muscularity a common theme?

    ____ Why is being thin or muscular so important?

    ____ Does being thinner mean being happier?

    ____ Will being thinner or more muscular allow an escape from pain?

13. What is the frequency of aerobic exercise?

    ____ Daily ____ Hours

    ____ Weekly ____ Hours

    ____ Bi-weekly ____ Hours

14. What is the frequency of bodybuilding?

    ____ Daily ____ Hours

    ____ Weekly ____ Hours

    ____ Bi-weekly ____ Hours

15. Is a decline in libido or a decreased interest in sexual behavior reported?

    ____ Are nocturnal emissions experienced?

    ____ Frequency

    ____ Is there an absence of desire for sexual intercourse or coupling?

16. Is sexual orientation or a sexual identity problem reported?

____ Sexually Active?

____ Gender of partner?

____ Nature of relationship?

____ Is this a satisfying sexual relationship? Why/Why not?

17. Is alcohol use reported? (Typically anorexics are not heavy alcohol users)

____ Frequency

18. Is drug use reported?

____ Which drugs are most commonly used?

____ Frequency

19. Are perfectionist tendencies present?

____ Are unreasonably high goals regularly established?

____ Is perfect performance expected in virtually all settings, i.e., work, school, school and professional relationships?

20. Are dependent tendencies present?

____ Are there expectations/demands for social approval and affection from others?

____ Is difficulty with making personal decisions a complaint?

____ Is pleasing others an important task?

21. Are obsessive-compulsive tendencies present?

____ Is there a preoccupation with orderliness?

____ Is excessive attention given to details as a means of maintaining a sense of personal control?

____ Is rigidity or inflexibility in thoughts and behavior reported?

22. Is a need for control expressed?

____ How is it manifested?

____ What happens if control is not maintained?

23. What fears are reported in regards to treatment? ______________________________

24. Is a manipulative or noncompliant persona present?

____ Does not follow through with treatment plan

____ Is overly compliant

*Initial draft of instrument. Reliability and validity studies have yet to be conducted. Copyright pending.

CHAPTER FIVE

Summary, Conclusions, Implications, and Recommendations

This final chapter provides a summary of the study and presents conclusions, implications, and recommendations. The problem for this study was that there are distinct characteristics of male anorexics that have been ignored by the mental health community resulting in underdiagnosis and mismanagement of the disease. Two major aspects of this problem included the fact that: (a) characteristics of the male anorexic are unclear to many mental health and medical professionals and (b) the DSM-IV definition is inadequate and gender-biased.

Three research questions were addressed to resolve the problem:

(a) What are specific characteristics of male anorexia?

(b) How can the DSM-IV definition of anorexia nervosa be broadened to provide a more comprehensive definition that includes males and females?

(c) What items are necessary for inclusion on an instrument for recognition and accurate assessment of anorexia nervosa in males?

This was an exploratory study and procedures employed relied primarily on a literature review and personal interviews with an expert panel. Panel members included mental health and medical practitioners, a male anorexic and a family member. Members were selected based on their personal and professional experiences with anorexia nervosa. They responded to the Assessment of Anorexia Nervosa in Males Questionnaire (AANMQ) that was developed from the literature review, a pilot survey, and interviews with Master's level Counselor Education students. This study confirmed the literature regarding discrimination males with eating disorders

face and presented evidence that anorexia nervosa is a growing problem among males in our society. It also revealed that despite the escalation of anorexic behavior in males, medical practitioners, mental health and school counselors are unaware of critical features that would typically alert one to identify these same symptoms in the female anorexic.

Summary of Findings

The AANMQ was designed for this study as a systematic means of assessing an expert panel's opinions and beliefs regarding anorexia nervosa among males. Utilizing information received from interviews with panel members and a literature review, the following findings emerged from this study:

1. Anorexia nervosa in males is a growing problem that continues to be ignored and misunderstand by many in academic, mental health, and medical professions.
2. The profile of male anorexics is similar to females in that they possess many of the same clinical features and characteristics. Predisposing events that result in eating disordered behaviors, however, are what separate males from females.
3. Male anorexics generally maintain low body weight through excessive exercise and restricted eating.
4. Three major dieting factors that distinguish eating disordered males from females include:
   (a) Males generally have been medically obese at some point in time.
   (b) Males diet to attain specific athletic goals.

(c) Males diet to avoid a potential health problem.

5. Anorexia nervosa in males is underdiagnosed primarily because most professionals believe that it is exclusively a female disorder.
6. The DSM-IV criteria for anorexia nervosa are gender-biased and need to be revised to include reference to endocrine functions in males.
7. There are a number of treatment gaps that exist for anorexic males with the most glaring being a lack of treatment/support groups that specifically address male issues.
8. There is disagreement among professional disciplines and the patient/family group represented on the expert panel about the underlying features of anorexia nervosa and how they are presented. The patient/family group responded to the AANMQ in a manner that was consistent with the literature as the archetype anorexic and family, an interactional style represented by high familial control, enmeshment, and an absence of support for autonomy (Connors, 1996).
9. There is a need for an instrument that assesses behavioral and emotional patterns of males.

Conclusions, Implications, and Recommendations

The following conclusions, implications, and recommendations are drawn from the study's findings and are reported in conjunction with each Research Question. Where appropriate, findings from the literature are briefly reiterated.

I. What are specific characteristics of male anorexics?

Conclusion: Anorexia nervosa is a disorder that affects over 1 million males and is spreading at an alarming rate. It is likely that this is an underestimate of the actual number who suffer from this disease; therefore, it must be acknowledged that anorexia in males is not an anomaly. Rather, it is a very real problem and can no longer be minimized. There are similarities and differences that exist between male and female anorexics with the psychological profile of males paralleling those of the female with similar premorbid features shared by each in that:

(a) Both engage in severe irrational thinking in their attempts to achieve personal control and autonomy.

(b) Both are consumed with feelings of self-doubt, perfectionism, and dependency all of which conflict with the need for control.

Anorexics experience incongruence between the need for control and the actual loss of control in addition to having a preoccupation with food and exercise. As a result, they live a socially isolated existence, feeling emotionally alienated from both peers and family members. This paradox further contributes to depression, which in turn contributes to an increased frenzy of eating disordered behavior. A vicious cycle at best! Moreover, the resemblance demonstrated between males and females once they become ill are quite similar. As such, an awareness of the underlying psychopathology, course, and onset must be addressed (Anderson, 1995). Presenting features of male and female anorexics are not dissimilar in that they share many of the same attributes of the disease. It is no more difficult to accurately assess this disorder in males than it is among females, but professionals must consider this as a possible diagnosis.

The following attributes detail the male anorexic profile:

(a) Male anorexics are often unaware that they have an eating disorder, falsely believing that anorexia is disease that affects only females.

(b) If males are aware that anorexia is a potential problem, they are hesitant to disclose their dysfunctional behaviors to family and friends or to seek professional treatment. Shame, interpersonal distrust, and difficulty with emotional expression are often cited as major hurdles to personal disclosure.

(c) Male anorexics like their female counterparts posses high body dissatisfaction.

(d) In contrast to female anorexics, the majority of male anorexics have been overweight prior to the development of their eating disorder.

(e) In addition to dieting, excessive exercise is often a precursor to anorexic behavior for males.

(f) Sexual orientation and sex role identification may be a concern.

(g) Social withdrawal or the tendency to be a “loner” is common.

(h) Characterological problems are often present with borderline, obsessive-compulsive, dependent, passive-aggressive, and avoidant traits being the most prominent.

(i) Depression is a common feature in anorexic males and is almost always a superimposed diagnosis.

(j) All anxiety disorders may be associated with anorexic males.

(k) The production of testosterone gradually decreases in anorexic males as a result of starvation.

(l) A loss of sex drive is experienced and sexual function diminishes.

(m) Like females, male anorexics are often perfectionists with low self-esteem, living life to the extreme while engaging in all-or-nothing thinking (Pelch, 1992). The anorexics' ability to control their weight in such a restrictive and rigid manner provides a false sense of personal effectiveness. However, when anorexics give in to their hunger, they then perceive themselves as failures which begins the downward spiral into a deeper, darker depression filled with negativistic and overgeneralized thinking.

(n) Unlike bulimics, anorexics rarely abuse alcohol due to the high caloric content. Additionally, alcohol serves as a disinhibitor which directly conflicts with the anorexics' desire for control.

(o) When drug abuse is present, the substances of choice frequently include marijuana, over the counter appetite suppressants, and prescribed medications.

Implication 1: Males are dying from anorexia nervosa and it is time to stop ignoring this issue. It is a problem of great magnitude that requires heightened recognition from medical practitioners, mental health professionals, and school counselors. It is commonly acknowledged that in general, males are more emotionally restricted than females and less likely to seek therapeutic services, especially for disorders they may not even be aware they are susceptible to such as anorexia nervosa. Furthermore, the characteristic styles males use in relating to others inhibits the development of a therapeutic relationship as intimacy is traditionally perceived as a personal invasion resulting in the loss of self (Wilcox & Forrest, 1992).

Recommendation: The helping professions must acknowledge anorexia nervosa is a disorder that affects both males and females and that there are differences between the sexes in

regards to eating disordered behavior. Every patient, therefore, must be individually assessed and treated based on his or her own unique needs. It is of extreme importance to enlighten not only mental health and medical practitioners, but also school personnel, i.e., school counselors, psychologists, and nurses as well as the general public regarding the severity of this problem in males. These professionals have direct contact with school-age children and their families on a daily basis and really must be viewed as the frontline in addition to being invaluable sources of information and referral. Although male anorexia nervosa is not as prevalent as some other psychiatric disorders, it demands attention and it is essential that the helping professions become acquainted with it and extend awareness to the community. To encourage mental health and medical practitioners to become better informed on this topic, incentives such as awarding continuing education credits may be warranted for attending a workshop that exclusively examines male anorexia nervosa. To ensure the school population is being educated on this topic, direct inservice training should be provided to all personnel. Additionally, school counselors can be trained to present a packaged workshop developed by the researcher and designed for presentation to the general population that conceptualizes male anorexia and the problems associated with it.

Implication 2: There is a stigma attached to anorexia nervosa among males. This is evident in the manner the anorexic male perceives himself, the quality and quantity of services available for this disorder among males, and the discrimination they face from insurance companies, managed care organizations, and health maintenance organizations who refuse to pay for treatment because “males don’t have anorexia” (Anderson, 1999).

Recommendations: The stigma attached to male anorexia nervosa must be eradicated. To a degree there is stigma attached to all psychiatric disorders, particularly among men, which is

one reason they so often present with one disorder when in fact they have another. For example, it is not unusual for the male to present with a substance abuse problem when depression is the real issue. If the "average" male has trouble expressing depression openly with friends, family or with a therapist, how is he going to feel about disclosing his anorexia? More importantly, how can the mental health community help alleviate the stigma attached to this disorder? There must be greater advocacy for male anorexics on both a local and national level.

Implication 3: There is inadequate education and training for school counselors, mental health, and medical practitioners in the area of male anorexia nervosa.

Recommendation: Academic programs must provide accurate instruction and training regarding the pathology of eating disorders and whom they affect. Classes offered in assessment and diagnosis of clinical psychopathology must include a section on male anorexia nervosa with an in-depth exploration of the topic.

II. How can the DSM-IV definition of anorexia nervosa be broadened to provide a more comprehensive definition that includes males and females?

Conclusion: The research clearly demonstrates that the criteria in DSM-IV for anorexia nervosa are gender-biased and account for many mental health and medical practitioners incorrectly or underdiagnosing this disorder in the male population. The mental health and medical professionals interviewed for this study confirmed previous findings that suggest discrepancies exist among different professional disciplines and their perceptions of the DSM-IV criteria in its application to anorexic males (Hsu, 1990). As a result, secondary diagnoses take precedence over anorexia and the eventual treatment males receive often is inadequate, as it does not address the psychopathology of self-starvation. Moreover, variables

that account for this disease and other related eating disorders in males are not completely understood as much of the research to date has relied on factors based on female anorexics (Keel et. al., 1997). No reference in the DSM-IV is made regarding lowered testosterone levels which is the closest male endocrine function that corresponds to the amenhorrea criterion and can be assessed easily by simply asking questions pertaining to sexual drive. There appears to be an emerging awareness on the mental health front to ask questions regarding sexual functioning, as evidenced by the practitioners' responses in this study. However, these questions are generally asked as a follow-up or precursor to medication that has been prescribed for symptoms related to the anorexia, such as depression rather than for diagnostic purposes. Differences among various mental health and medical disciplines represented in this study and previous research findings confirm the necessity of updating the diagnostic features DSM-IV.

Implication 1: Patients need to be properly assessed and diagnosed.

Recommendation: Reference to males and anorexia nervosa in the DSM-IV are essentially nonexistent. Therefore, the contents must be updated to include the mention of males, specifically endocrine function, to prevent misdiagnoses. Researchers must make the American Psychiatric Association (APA) aware of the gender-biased language and omission of males in its criteria for anorexia nervosa. Clearly, there are a handful of contributing advisors to the DSM-IV who are cognizant of this problem but the criteria remains unchanged. The DSM-IV is the "bible" to all practitioners in the mental health field and serves as a guide to diagnosing every psychiatric disorder. Greater persistence from researchers and more direct contact with APA is imperative to make these necessary changes.

III. What items appear necessary for inclusion on an instrument for mental health and medical practitioners to assess for anorexia nervosa in males?

Conclusion: There is not a consistent evaluative measurement tool for assessing anorexia in males. Therefore, an instrument that outlines diagnostic features and risk factors of anorexic males is essential for improved assessment and diagnosis in this population. Items on the instrument should be designed in such a manner that would allow practitioners to more effectively recognize both psychological and physical aspects of this disease. There is a uniqueness of males that absolutely differentiates them from females. As such, the instrument must include items that address these distinctive characteristics as well as the similarities they share with their female counterparts. Males are not difficult patients to diagnose but due to a lack of information regarding males and eating disorders, appropriate evaluations are likely to remain elusive.

Implication 1: An instrument that addresses specifics related to anorexia nervosa in males is greatly needed.

Recommendation: Utilizing the practitioner and theory based instrument designed in this study, the Assessment for Male Anorexia Nervosa (AMAN) could heighten awareness of the symptoms associated with this disorder for school counselors, mental health and medical professionals and lead to a more definitive profile of this disease. Consequently, it would allow these professionals to make more appropriate diagnoses.

Future Research

This study provided an exploratory examination of the problem of male anorexia nervosa. Keeping this in mind, along with the small sample size, caution must be made in regards to

applying the findings to the overall mental health and medical community. It is recommended a similar study be conducted using a larger sample for the expert panel as a means of furthering the conceptualization and construct of male anorexia nervosa. It would be especially helpful to have a second investigative study with a greater number of male anorexics represented to discern the generality of this study's findings. The Assessment of Anorexia Nervosa in Males Questionnaire (AANMQ) can be utilized in future studies to assess a larger sample of patients, family members, mental health and medical practitioners and consequently further generalize the findings found in the context of this study. It is also recommended that the Assessment of Male Anorexia Nervosa (AMAN) be piloted and tested for reliability and validity. The research-based content in the AMAN provides a solid basis for recognizing anorexia nervosa in males. With its use, clinicians can learn an abundance of information about male clients which will result in an accurate diagnosis of male anorexia nervosa.

RESEARCHER'S COMMENTS

Throughout the course of this study I was regularly challenged with problems that reinforced the need for the topic being researched, male anorexia nervosa. The information on this topic was limited with many of the authors writing in this area referencing each other and stressing the importance of further research. Additionally, to assemble an expert panel was extremely difficult. Many of the professionals I contacted either had no experience in working with male anorexics or their interactions were brief. Several chose not to participate in the study or did not return phone messages. My efforts to locate male anorexics and their family members were impeded by the infrequency in which this diagnosis is made among males, confidentiality issues, and the disposition of this type patient who often seeks help when in crisis and then disappears from treatment with no follow-up. Several of the professionals I interviewed remarked that in retrospect, they may have missed this diagnosis in several of their patients, treating only the symptoms related to the eating disordered behavior. Consequently, they did not refer these patients to me as they could not definitively claim anorexia nervosa as the primary diagnosis.

By the end of this dissertation I developed an even greater sense of empathy for the male anorexic as I experienced firsthand the ignorance of the professional and lay community in regards to anorexia nervosa among males. Upon contacting treatment centers that specifically treat eating disorders I was informed that either no services were provided for males, treatment was available but it was not specialized or designed for the male patient, or anorexia nervosa is a female disorder that is caused and perpetuated by males. Throughout my discussions with the panel members and hospital and insurance company representatives, I discovered the inequity of insurance coverage for eating disorders in males. The father of the male anorexic on the expert

panel reported his insurance plan paid over $300,000 for treatment his son received on a medical unit. However, upon accessing his mental health benefits, case managers from the managed care company initially denied psychiatric treatment to the patient as they did not perceive anorexia nervosa to be a significant or prevalent disorder among males. Upon winning this battle, the family then faced the hurdle of finding a therapist who specialized in male anorexia nervosa.

My research allowed me to become much more cognizant of the sexist slant in articles written for popular magazines and professional journals regarding males and anorexia nervosa. Males are generally afforded a one-line sentence that mentions they may be susceptible to an eating disorder, but with few exceptions, the remainder of these articles focus on females. This reinforces a quote referenced in the dissertation by Michael Krasnow and bears repeating. "My parents and I could not pick up a book and read about male anorexics. For all we knew, I was the only man in the world with anorexia " (Krasnow, 1996, p. 24).

I hope this study will be a positive addition to the growing body of literature on male anorexia nervosa and will serve as a guide for further research in this area.

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Appendix A

DSM-IV Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenhorrea if her periods occur only following hormone, e.g., estrogen administration.)

Specify **Type:**

Restricting Type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas)

Appendix B

Assessment of Anorexia Nervosa in Males Questionnaire

Part I. Respondent Information

1. What is your current professional position?
2. Please list all applicable licenses.
3. How long have you worked with anorexic clients?
4. What ages and gender do you treat?
5. How many males have you treated qualify as anorexic (as defined by the DSM-IV) on AXIS I ____, AXIS III______?
6. How prevalent do you consider males and Anorexia Nervosa?
7. Do you believe it is underdiagnosed among males? Why/Why Not?

Part II. Assessment and Diagnosis

1. How do you assess for Anorexia Nervosa in males?
    a. What criteria do you utilize? Is it based on weight and height using a standard table, e.g., Metropolitan Life or National Center for Health? Reliance on self-report to identify if the patient has an intense fear of gaining weight or possesses a disturbed body image? Are questions asked regarding endocrine functioning?
2. Does the patient present with a distorted body image? (Define distorted body image)
3. Is the patient's thinking "psychotic-like" in regards to these distortions? If so, how?
4. Are anti-psychotic medications prescribed for the distorted thinking? Explain.

5. What if any co-morbid disorders are most commonly diagnosed in anorexic males?
    a. Mood disorders - which ones?
    b. Personality disorders - which ones?
    c. Others?
6. What is the incidence of alcohol abuse?
7. What is the incidence of drug abuse?
8. Have your male patients discussed sexual identity issues? Describe the problem.
9. What are the most common medical complications involved with the male anorexic?

Part III. Treatment

1. How common is noncompliance with this type patient?
2. How is it manifested?
3. Does the patient present a specific persona in order to be discharged?
4. What levels of care (outpatient, inpatient, partial) are provided?
5. What is the typical length of treatment for each setting?
6. What therapeutic approach is used?
7. How are support groups utilized?
    a. Do men participate in groups designed primarily for women?
    b. What is the impact of the male's participation in these groups?
    c. How do they "fit in" in these settings?
    d. Do you have any groups designed specifically for the male anorexic?

Part IV. Medications

1. How often is medication prescribed?
2. What are the medications typically prescribed?
3. How do these medications correspond with co-morbid disorders?

Part V. Additional Variables and Comments

1. Have you noticed a difference in socioeconomic status in the male anorexic patients as compared to their female counterparts?
2. How involved are the family members of your male patients?

Appendix C

Grouped Responses of Expert Panel on the AANMQ

I. Respondent Information

1. What is your current position?

Mental Health Group
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Professional Counselor
- Psychologist

Medical Group
- Psychiatrist
- Pediatrician
- RN
- Dietician

Patient/Family Group
- Male Anorexic
- Parent

2. List all applicable licenses

Mental Health Group

LCSW	Licensed Clinical Social Worker
LPC	Licensed Professional Counselor, Registered Nurse
LPC	Licensed Professional Counselor
Psychologist	Licensed Clinical Psychologist, Registered Nurse, Master's in Psychiatric Nursing

Medical Group

Psychiatrist	Board Certified General Psychiatrist, Registered Music Therapist
Pediatrician	Medical Doctor, Board Certified Pediatrician
RN	Registered Nurse
Dietician	Registered Dietician

Patient/Family Group

Male Anorexic	N/A
Parent	N/A

3. How long have you worked with anorexic clients?

Mental Health Group

LCSW	6 years
LPC	8 years
LPC	6 years
Psychologist	14 years

Medical Group

Psychiatrist	10 years
Pediatrician	7 years
RN	13 years
Dietician	10 years

Patient/Family Group

Male Anorexic	N/A
Parent	N/A

4. What ages and gender do you treat?

Mental Health Group

LCSW	Age: 16-25 years, Youngest male treated was 12 years old Gender: Primarily females but 4 males, 3 were inpatient
LPC	Age: 10-40's Gender: Primarily females, sporadically treated males
LPC	Age: Primarily adults Gender: Primarily females, several males
Psychologist	Age: 14 through early 20's Gender: Both male and female

Medical Group

Psychiatrist	Age: Adolescence - 50's Gender: Mainly females, a few males
Pediatrician	Age: 0-21 Gender: Both male and female - 2 males with eating disorders
RN	Age: 13-18 Gender: Primarily female but males too
Dietician	Age: All ages Gender: Both males and females

Patient/Family Group

Male Anorexic	N/A
Parent	N/A

5. How many males have you treated qualify as anorexic on AXIS I, AXIS III?

Mental Health Group

LCSW	AXIS I: All AXIS III: 0
LPC	AXIS I: All AXIS III: Gastritis in addition to the anorexia
LPC	AXIS I: 2 AXIS III: 0
Psychologist	AXIS I: 3 AXIS III: 1

Medical Group

Psychiatrist	AXIS I: All AXIS III: 0
Pediatrician	AXIS I: 1 AXIS III: N/A
RN	AXIS I: All AXIS III: 0
Dietician	AXIS I: All AXIS III: 0

Patient/Family Group

Male Anorexic	AXIS I: N/A AXIS III: N/A
Parent	AXIS I: N/A AXIS III: N/A

6. How prevalent do you consider males and anorexia nervosa?

Mental Health Group

LCSW	Don't Know
LPC	Less than 10% - 1%-3%, because of menstruation criterion we miss them
LPC	Less than 10% - Not that common
Psychologist	More common - Very common especially with advent of body building

Medical Group

Psychiatrist	Less than 10% - Often comorbid with substance abuse
Pediatrician	Don't know
RN	Less than 10%
Dietician	More common - Usually secondary diagnoses

Patient/Family Group

Male Anorexic	Don't know
Parent	Don't know

7. Do you believe it is underdiagnosed among males? Why/Why not?

Mental Health Group

LCSW	Yes - Low body fat
LPC	Yes - Miss them due to menstruation criteria
LPC	Yes - Tied to other disorders
Psychologist	Yes - The right questions are not being asked

Medical Group

Psychiatrist	Yes - Because of comorbid diagnoses they may carry. They will receive tx for these but not the anorexia. More accepted in females.
Pediatrician	No opinion
RN	Yes - Males don't believe they have a problem.

Dietician	Yes - Primary dx takes precedence.

Patient/Family Group

Male Anorexic	No opinion - Don't know but it is likely.
Parent	No opinion

II. Assessment and Diagnosis

1. A. How do you assess for anorexia nervosa in males?

Mental Health Group

LCSW	Body Mass Index, Body Percentage, Self Report, Nutrition, Growth Chart (for children)
LPC*	Body Mass Index, Self Report
LPC	Body Mass Index, Mental Exam, Psychosocial
Psychologist	Nutritionist, APA Guidelines DSM-IV, Early Develop History

Medical Group

Psychiatrist	Body Mass Index, Body Percentage
Pediatrician	Self Report, Family Report
RN	Nutritionist, APA Guidelines DSM-IV
Dietician†	Body Mass Index, Self Report

Patient/Family Group

Male Anorexic	N/A
Parent	N/A

B. Are questions asked regarding endocrine functioning?

Mental Health Group

LCSW	No
LPC	No - refer to MD for physical
LPC	No
Psychologist	Yes - because meds can affect sexuality

Medical Group

Psychiatrist	Yes - in regards to SSRI follow up
Pediatrician	No
RN	No
Dietician	No

* Uses a checklist
† Labs, nursing assessment, height/weight/eating history

Patient/Family Group

Male Anorexic	No
Parent	No

2. Does the patient present with a distorted body image?

Mental Health Group

LCSW	Yes
LPC	No - usually never, more likely depression and family problems
LPC	Yes
Psychologist	Yes

Medical Group

Psychiatrist	Yes - in females only
Pediatrician	Yes
RN	Yes
Dietician	Yes - sometimes, I don't have same contact with the patient as Other clinical staff

Patient/Family Group

Male Anorexic	No - "I look good," "I want to gain weight"
Parent	No

3. Is the patient's thinking "psychotic-like" in regards to the distortions?

Mental Health Group

LCSW	Yes - due to low body fat
LPC	Yes - convinced their reality is real and no one can change Their minds, believes everyone else is wrong
LPC	Yes
Psychologist	Yes

Medical Group

Psychiatrist	No - never seen
Pediatrician	No - never seen, limited experience
RN	Yes
Dietician	No - seldom

Patient/Family Group

Male Anorexic	No
Parent	No

4. Are anti-psychotic medications prescribed for the distorted thinking?

<u>Mental Health Group</u>

LCSW	Yes - Risperdal, Prozac
LPC	Yes - more now than ever before
LPC	No
Psychologist	Yes - Risperdal

<u>Medical Group</u>

Psychiatrist	No - more reliance on SSRI's
Pediatrician	No
RN	Yes - Risperdal, Zyprexa
Dietician	Yes - but seldom

<u>Patient/Family Group</u>

Male Anorexic	No - Zoloft and Prozac for depression
Parent	No - Prozac

5. Co-morbid disorders most commonly diagnosed in anorexic males?

<u>Mental Health Group</u>

LCSW	Mood: Depression Personality: Borderline, Obsessive-Compulsive
LPC	Mood: Depression, Bipolar, Dysthmic Disorder Personality: Borderline, Dependent, Avoidant
LPC	Mood: Depressive Disorder-NOS, Dysthymic Disorder Personality: Dependent, Passive-Aggressive
Psychologist	Mood: Dysthymic Disorder Personality: Borderline, Passive-Aggressive

<u>Medical Group</u>

Psychiatrist	Mood: Depression Personality: Dependent Other: Posttraumatic Stress Disorder
Pediatrician	
RN	Mood: Depression, Bipolar, Dysthymic Disorder Personality: Cluster B (emotional, erratic, dramatic traits)
Dietician	Mood: Depression Personality: Obsessive Compulsive

Patient/Family Group

Male Anorexic	Mood: Depression Other: Anxiety
Parent	Mood: Depression/Angry Other: Anxiety

6. Incidence of alcohol abuse?

Mental Health Group

LCSW	Yes - but seldom due to high calories of alcohol
LPC	Yes - race due to calories, see more in bulimics
LPC	Yes - but it is low
Psychologist	Yes - but more with bulimics

Medical Group

Psychiatrist	Yes - pretty high, use to self-medicate
Pediatrician	N/A
RN	Yes - but seldom with adolescents
Dietician	Yes - fairly common

Patient/Family Group

Male Anorexic	No
Parent	No

7. Incidence of drug abuse?

Mental Health Group

LCSW	Yes - but seldom
LPC	Yes - very high among bulimics but rare for anorexics due to not wanting to be out of control
LPC	Yes - amphetamines
Psychologist	Yes - marijuana

Medical Group

Psychiatrist	Yes - quite often but higher incidence of alcohol
Pediatrician	
RN	Yes - not much without adolescents, maybe use pot
Dietician	Yes - fairly common

Patient/Family Group

Male Anorexic	No
Parent	No

8. Do you discuss sexual identity issues with your patient?

Mental Health Group

LCSW	Yes - only once because he wanted a sex change
LPC	Yes - major part of their work, gay, lonely and wanting to look "buffed" to obtain a partner
LPC	No
Psychologist	Yes - more conflict with identity associated with sexual abuse in early ages

Medical Group

Psychiatrist	No
Pediatrician	
RN	Yes
Dietician	No

Patient/Family Group

Male Anorexic	No
Parent	No

9. Common medical complications of the male anorexic?

Mental Health Group

LCSW	Kidney, Heart, Electrolyte Disturbance
LPC	Kidney, Heart, Electrolyte Disturbance, Loss of Bone Density
LPC*	None Reported - saw on outpatient basis
Psychologist	Kidney, Heart, Electrolyte Disturbance, Loss of Bone Density, Impaired Metabolism

Medical Group

Psychiatrist	Kidney, Heart, Impaired Metabolism
Pediatrician	Kidney, Heart, Electrolyte Disturbance, Loss of Bone Density, Impaired Metabolism
RN	Kidney, Heart, Impaired Metabolism
Dietician	Kidney, Heart, Electrolyte Disturbance

Patient/Family Group

Male Anorexic	Diarrhea - due to Chrones disease
Parent	Diarrhea - severe due to many medical problems

* Dehydration, constipation, low blood pressure, inability to concentrate

III. Treatment

1. How common is non-compliance with male anorexic?

Mental Health Group	
LCSW	Very Common - similar to females
LPC	Very Common
LPC	Very Common - very high
Psychologist	Very Common

Medical Group	
Psychiatrist	Never - desperate for treatment
Pediatrician	Very Common
RN	Very Common
Dietician	Seldom Common - trying the best they can

Patient/Family Group	
Male Anorexic	Seldom Common
Parent	Seldom Common

2. How is non-compliance manifested?

Mental Health Group	
LCSW	Denial, resistance to treatment
LPC	Resistance to treatment - no follow through
LPC	Cancels appointments no follow-up
Psychologist	Deception of what they eat

Medical Group	
Psychiatrist	None
Pediatrician	Cancels appointments no follow-up
RN	Resistance to treatment - pull out IV's
Dietician	None - male tend to work on their issues

Patient/Family Group	
Male Anorexic	None
Parent	None

3. Does the patient present with a specific persona to be discharged?

<u>Mental Health Group</u>

LCSW	No
LPC	Yes - agree to requests, then don't do anything
LPC	N/A
Psychologist	Yes - eat prescribed amounts then starve self again upon hospital discharge

<u>Medical Group</u>

Psychiatrist	No
Pediatrician	Yes
RN	No
Dietician	No

<u>Patient/Family Group</u>

Male Anorexic	Yes - compliant with treatment
Parent	Yes - compliant with treatment

4. What levels of care are provided for this patient (by provider)?

<u>Mental Health Group</u>

LCSW	Outpatient
LPC	Inpatient, Outpatient, Partial (none available – if there were referrals would be made)
LPC	Outpatient
Psychologist	Inpatient, Outpatient, Partial

<u>Medical Group</u>

Psychiatrist	Inpatient
Pediatrician	Inpatient, Outpatient
RN	Inpatient, Outpatient, Partial
Dietician	Inpatient, Outpatient

<u>Patient/Family Group</u>

Male Anorexic	Inpatient, Outpatient, Partial
Parent	Inpatient, Outpatient, Partial

5. What is typical length of treatment? (All report that managed care impacts treatment delivery.)

Mental Health Group

LCSW	Inpatient: 2 weeks Outpatient: 1-2 years
LPC	Inpatient: 10 days Outpatient: Forever
LPC	Outpatient: 5 sessions - drop off after that
Psychologist	Inpatient: 6-10 days Outpatient: Long term

Medical Group

Psychiatrist	Inpatient: 10-14 days Outpatient: Depends
Pediatrician	Inpatient: 1-2 weeks Outpatient: Patient "bolted" – referred out, psychologist dismissed due to non-compliance
RN	Inpatient: 12-5 days Outpatient: 1 year follow-up
Dietician	Inpatient: 7 days Outpatient: 2 months

Patient/Family Group

Male Anorexic	Inpatient: Approximately 1 month Outpatient: Long term
Parent	Inpatient: 2 weeks Outpatient: Long-term – approximately 2 years

6. What therapeutic approach is used?

Mental Health Group

LCSW	Cognitive-Behavioral, Group (when available)
LPC	Cognitive-Behavioral (teach normalized eating), Individual (solution focused and insight oriented)
LPC	Cognitive-Behavioral
Psychologist	Cognitive-Behavioral, Individual, Family, Group (when available)

Medical Group

Psychiatrist	Psychodynamic, Individual
Pediatrician	
RN	Cognitive-Behavioral
Dietician	Cognitive-Behavioral

Patient/Family Group

Male Anorexic	Individual, Family, Group
Parent	Individual, Family, Group

7. Are support groups utilized?

Mental Health Group

LCSW	Yes - But currently none available. Last one offered on outpatient basis for 2 years ago – no males participated. For inpatient, when males participate, they add a great deal.
LPC	No - None available in this area (NRV)
LPC	No - None offered in the area (NOVA)
Psychologist	Yes - Just beginning to offer

Medical Group

Psychiatrist	No - unless a group for co-morbid disorder, example AA
Pediatrician	No - N/A
RN	Yes - Educational and 12-step
Dietician	Yes - I provide groups for education and support only

Patient/Family Group

Male Anorexic	Yes - But did not openly participate due to being only male
Parent	Yes - Son felt no sense of belongingness due to being only male and not seeing self as anorexic

IV. Medications

1. How often is medication prescribed?

Mental Health Group

LCSW	Frequently to always
LPC	Frequently to always
LPC	Frequently to always
Psychologist	Frequently to always

Medical Group

Psychiatrist	Frequently to always
Pediatrician	Frequently to always
RN	Frequently to always
Dietician	Frequently to always

Patient/Family Group

Male Anorexic	Frequently to always
Parent	Frequently to always

2. What are the typical medications prescribed?

Mental Health Group

LCSW	SSRI Antidepressants: Prozac Luvox, Paxil, Zoloft, Effexor
LPC	SSRI Antidepressants
LPC	SSRI Antidepressants
Psychologist	SSRI Antidepressants: Usually works for depression and anxiety

Medical Group

Psychiatrist	SSRI Antidepressants: Zoloft, Paxil, Prozac
Pediatrician	None: Prescribed by referring psychiatrist
RN	SSRI Antidepressants: Prozac, Paxil, Zoloft, Luvox, Effexor, Anafranil
Dietician	SSRI Antidepressants

Patient/Family Group

Male Anorexic	SSRI Antidepressants: Zoloft – currently medication free
Parent	SSRI Antidepressants: Prozac

3. How do these medications correspond with co-morbid disorders? (All agree food is best medicine.)

Mental Health Group

LCSW	Clears thinking/relieves depression and delusional thoughts
LPC	Clears thinking/relieves depression and delusional thoughts, Clears obsessive thinking
LPC	Little impact
Psychologist	Clears thinking/relieves depression and delusional thoughts

Medical Group

Psychiatrist	Clears thinking/relieves depression and delusional thoughts
Pediatrician	

RN	Clears thinking/relieves depression and delusional thoughts
Dietician	Clears thinking/relieves depression and delusional thoughts

Patient/Family Group

Male Anorexic	Little impact
Parent	Little impact

V. Additional Variables and Comments

1. Have you noticed a difference in socioeconomic status in the male anorexic patients as Compared to their female counterparts?

Mental Health Group

LCSW	No
LPC	No
LPC	No
Psychologist	No

Medical Group

Psychiatrist	No
Pediatrician	No
RN	No
Dietician	No

Patient/Family Group

Male Anorexic	No
Parent	No

2. How involved are the family members of your male patients?

Mental Health Group

LCSW	Never involved
LPC	Never involved
LPC	Never involved
Psychologist	Very, Over involved, Infrequently involvement, Never involved

Medical Group

Psychiatrist	Infrequent involvement
Pediatrician	Over involved
RN	Infrequent involvement - Depends on family and patient
Dietician	

Patient/Family Group

Male Anorexic	Very

Parent	Very

Additional Comments:

Mental Health Group

LCSW	DSM-IV: Needs to be more straight forward for diagnosing males. Usually wind up diagnosing Eating Disorder, NOS or depression even though it is the wrong diagnosis. Treatment gaps: They exist! Groups for males: We need to provide groups for males.
LPC*	DSM-IV: For eating disorders-definitely! Treatment gaps: Yes Groups for males: Have treatment facilities for males, recognize males are not a version of females, they have unique issues and they discuss these issues differently than females.
LPC	DSM-IV: Nothing wrong with the criteria—I just exclude amenorrhea. Treatment groups: They exist but not enough males to offer specialized services like groups just for males. Bring them in co-ed groups and encourage participation.
Psychologist	DSM-IV: Yes!

Medical Group

Psychiatrist	DSM-IV: Absolutely gender-biased, criteria makes it easier to diagnosis females.
Pediatrician†	Groups for males: Possibly – maybe male anorexics are more loners – would a group work?
RN	DSM-IV: It is gender-biased – we probably are missing some males due to criteria.
Dietician	DSM-IV: I do not diagnose. Treatment gaps: No Groups for males: Clients under utilize services. Providers are eager to supply services.

* LPC – Counselors need to become better educated in relation to diagnosing and base treatment on symptoms, not just a diagnosis. Treat the person as an individual.

† Pediatrician – Poor prognosis for this client when such a long-term history (first diagnosed at 12 years), family overly involved, very dysfunctional family-many "partners," everyone has an investment in keeping patient "sick," patient appears to want to avoid or delay puberty.

Patient/Family Group

Male Anorexic	DSM-IV: N/A Treatment gaps: Would like a hospital program for males only. Need to ask the male about his issues and what is wrong. Do not assume it is the same for males and females. Groups for males: This would be better – allow us to talk about our issues.
Parent	Treatment gaps: Yes, there are gaps. His son did not have the prototype symptoms and was unhappy with his hospitalization. Groups for males: Yes, son did not participate in coed groups because no sense of belongingness.

VITAE

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EMPLOYMENT

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