Irish Male Anorexia: Prevalence, Presentation and Treatment, an Investigation

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Table of Contents

ABSTRACT

Available data on anorexia suggests an increase in the prevalence among the male population in Western cultures. Individual Irish agencies providing treatment for eating disorders suggest a rise in the presentation of male anorexia. This thesis investigates whether the reported rise in presentation in Ireland reflects an actual increase in the number of those with the illness. The aim of the study is to identify issues, raise awareness of this male illness and to identify recommendations for the field of psychotherapy. A qualitative research strategy was adopted to identify themes and patterns and to gain a deeper understanding of the issues surrounding the illness. Semi-structured interviews were conducted with five practitioners currently working in the field. Findings were organized and themes and patterns identified, using thematic content analysis. Analysis of the research shows that male anorexia is increasing in presentation but not necessarily in prevalence, but is misrepresented in statistical information. The research shows similarities between genders but acknowledges some differences in the manifestation and root causes of the illness. A lack of understanding of the manifestation and root causes of male anorexia in Ireland, together with stigmas associated with the illness, often lead to misdiagnosis of the illness. This study shows that male anorexia is a complex illness that can become entrenched and, if not treated properly, can in some cases, end in fatality. Findings show psychotherapy to be effective in the treatment of male anorexia as part of a multidisciplinary treatment approach. The conclusions drawn from this study include recommendations for appropriate training to be given to psychotherapists and for a new approach to be taken in the advertising of counselling and psychotherapy services to male sufferers.

1 INTRODUCTION

This study aims to investigate the prevalence of male anorexia in Ireland, a potentially life threatening mental and behavioural illness. The study will explore why it is a growing concern, and investigate whether it is increasing in prevalence or presentation. The study sets out to examine the manifestations and root causes of the illness and aims to identify and examine available treatment modalities in Ireland. This study aims to provide recommendations that will address the idea that male anorexia is under diagnosed in Ireland and provide recommendations for the field of psychotherapy in relation to the illness.

The following thesis is set out by firstly analysing the available literature on the subject, which suggests that male anorexia is a psychiatric and medical morbidity, that is less prevalent in males compared to females, but is reported to be increasing. The research also suggests that male anorexia may be underestimated and further research into its prevalence is required. The methodology adopted and described in the thesis is a qualitative study utilising semi-structured interviews. The analysis model utilised is a thematic content analysis and this is presented and discussed. Among the findings drawn, this thesis concludes that there may not be a significant increase in prevalence but in presentation and that specific actions need to be taken in order to increase awareness of the illness and to equip psychotherapists with the relevant skills and knowledge.

2 LITERATURE REVIEW

Anorexia is a potentially life threatening mental and behavioural illness, that that has serious psychiatric and medical implications. Typically considered a female disorder, male anorexia is now a growing concern with statistics indicating an increase in its prevalence. This paper will discuss the prevalence and presentation of male anorexia, examine the manifestation and root causes of the illness and discuss treatment approaches, including the effectiveness of psychotherapy.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994), describes anorexia nervosa as; "a severe, life-threatening disorder in which the individual refuses to maintain a minimally normal body weight, is intensely afraid of gaining weight, and exhibits a significant distortion in the perception of the shape or size of his body, as well as dissatisfaction with his body shape and size". This psychiatric illness also reports concerning high incidences of mortality and comorbidity (Attia, 2010). Anorexia nervosa, associated with a number of conditions that can affect an individual psychologically, physically and socially, is often characterised by a disturbance in eating behaviours and a distorted attitude to weight and shape (George Hsu, 1990). Anorexia nervosa is diagnosed when an individual controls their weight and refuses to gain weight by using any one of following methods: under eating, vomiting, exercising excessively or taking laxatives, to such an extent that they are at least 15 percent under what is considered to be a healthy weight (American Psychiatric Association, 2005). According to the American Psychiatric Association (2005) untreated cases of anorexia nervosa can

result in malnutrition and severe starvation and a weakening of the heart muscles causing irregular or abnormal heart rates. Severe cases can lead be fatal.

Originally recognised by Morton (1694), 'anorexia nervosa' was first named by Sir William Withey Gull (1816-1890) in a paper published in 1874. Although Gull noted it to occur mainly in young females between the ages of 16 and 23, he changed the original term "apepsia hysterica", thought to be a female illness, to "anorexia nervosa", meaning "nervous loss of appetite" due to the identification of its prevalence in males. Despite this early detection of male anorexia, it has traditionally been considered an illness that affects females, and in particular teenage girls.

The Eating Disorder Resource Centre of Ireland suggest an increase in the presentation of male anorexia and figures from the Department of Health estimate that as many as 200,000 people in Ireland may be affected by eating disorders, but do not stipulate the ratio of male to female. Their figures show an estimated 400 new cases annually, with 80 cases ending in fatalities. Anorexia in both males and females is considered to have the highest mortality rate of any other psychiatric disorder. The DSM-IV (American Psychiatric Association, 1994), report the prevalence of male anorexia to be approximately one-tenth that among females. Other statistics report the prevalence to be less than fifteen times that of female anorexia (Abraham & Llewellyn-Jones 1999). However, some studies have argued that the actual number is closer to one in six (Andersen, 2002). A report by Zhao and Encinosa (2009) shows figures for the hospitalisation of patients with eating disorders in the United States.

They report a 37 percent increase in the amount of males admitted in the time period from 1999-2000 to 2005-2006. This compares to a 16 percent increase in the number of female patients admitted. However, Zhao and Encinosa argue that statistics for the hospitalization of patients with eating disorders are an inaccurate representation of the illness, as many patients are admitted and recorded with other primary diagnoses.

Abraham and Llewellyn-Jones (1999) suggest that, although less prevalent than in females, male anorexia is becoming increasingly prevalent. A study comparing males and females with DSM-IV-defined eating disorders, admitted to the inpatient eating disorders service at the New York Hospital, Cornell between 1984 and 1997, reported a steady increase in the percentage of males admitted to the eating disorder unit. Their findings also showed that males were more likely to have a later onset of their eating disorder and to be involved in an occupation or sport in which weight control influences performance. According to Sacker and Zimmer (1987), an increasing number of male adolescents and young adults are diagnosed as anorexic, with the onset of illness occurring before the age of 25. Furthermore, the disorder can remain entrenched beyond the age of 30. However, Braun, Sunday, Huang and Halmi (1999) suggest that, due to chronological trends in the prevalence rates of eating disorders among men not having been clearly established, it is difficult to get a clear understanding of its rate of increase.

Braun et al (1999) report that although male and female anorexia are similar in their characteristics, course, behaviours and comorbid psychopathology and despite similar approaches being adopted for treatment, the illness is still considered to be a female one. Some research points to the fact that anorexia may be under-diagnosed in males (Schneider & Agras, 1987). Further research supports the view that male anorexia is underestimated; a published survey of a community sample shows that males represent nearly 25% of all eating disorders reported (Hudson, Hiripi, Pope & Kessler, 2006). This statistic suggests the prevalence of male anorexia may be under-estimated due to the unwillingness of men to come forward and seek treatment. In their study on the prevalence of the male disorder, Hudson et al (2006) conclude by saying that eating disorders "although relatively uncommon, represent a public health concern because they are frequently associated with other psychopathology and role impairment, and are frequently under-treated". Whelan (2002) also identifies a lack of awareness with some health professionals as to the fact that eating disorders can affect men; further causing cases to be undiagnosed.

There are a number of factors that have been identified as influencing the onset of male anorexia including traits, society, genetics, the role of family and brain activity. Whelan (2002) suggests traits associated with the disorder include an obsession with thinness, body dissatisfaction, low self-esteem and a tendency towards perfectionism.

Ogden (2003) suggests that sociocultural influences have an effect on the causes of anorexia. Hsu and Lee (1993) suggest that people in Western cultures typically desire

a thin appearance or particular body shape, leading to anorexia being more prominent in such cultures. Bordo (2003) suggests that there is more social pressure on females in Western cultures to have a certain body image, with males being more likely to be judged on achievements rather than looks. However, despite a greater pressure reported for women to conform to a particular body image, (Anderson & DiDomenico, 1992), research does suggest that boys are under increasing pressure to conform to a particular body image (Grogan, 2008). Henwood, Gill and McLean (2002) tell us that men are becoming more defined by their bodies. They tell us that the male body, as represented by the media, is becoming increasingly represented as a slender and muscular ideal. A report by McNicholas, Lydon, Lennon and Dooley (2009) highlights the influence the media may be having on the perspectives of young Irish people with regards to body weight and shape. Their report shows the majority of young Irish individuals feeling adversely affected by unrealistic media representations of an ideal body image. Many of those were also found to have issues with body satisfaction and perceived popularity.

According to Braun et al (1999), dysfunctional eating is often seen as an initiator of an eating disorder, with additional risk factors being present to create a distorted attitude to eating, body shape or weight (Siever, 1994, Stieger, 1989). King and Mezey (1987) and Stoutjesdyk & Jevne (1993) suggest such additional risk factors may include participation in activities that require particular attention to be paid to body shape and weight. Examples of risk factors suggested by Braun et al., (1999) include involvement in professions, sporting activities and hobbies where particular body

image, shape or weight is correlated with good performance. Men with occupations such as modelling, dancing and jockeying are cited by Buckley, Freyne, and Walsh (1991) as vulnerable examples of those required to conform to a particular body shape or weight. Other professions can include acting and those in high-visibility and high-glamour jobs. Certain sports also require specific body weights and sizes, resulting in sportsmen and athletes being potentially more prone to an eating disorder. However, O'Drea and Yager (2006) argue that there is not enough research on the correlation between body image, dieting, and eating behaviours in the male population and that further research is required in this area.

Morgan and Arcelus (2009) suggest that gay men are particularly vulnerable to the impact of media and peer group influences. Reported cases of eating disorders are higher among homosexual men than among heterosexual men (Siever, 1994; Carlat, Camargo, & Herzog, 1997). Gay men account for 5-10% of anorexia cases with figures showing the illness to be increasing amongst males (Lucas, Beard, Kurland & O'Fallon, 1991; Sharp, Clark, Dunan, Blackwood, & Shapiro, 1994). Conner, Johnson and Grogan (2004) tell us that homosexual men are more likely to be impacted by the pressure to conform to a slender ideal, to have low body satisfaction. They report that gay men are at greater risk from suffering from an eating disorder. However, Whelan (2002) theorises that the illness being considered a 'gay' problem or a 'female' problem only contributes to the illness being under-diagnosed in males.

Research tells us that anorexia can be transmitted in families (Strober, Freeman, Lampert, Diamond, & Kaye, 2000) with genetics influencing the onset of the disorder, combined with other factors or causes (Kaye, Lilenfeld, Berrettini, Strober, Devlin, Klump, Goldman, Bulik, Halmi, Fichter, Kaplan, Woodside, Treasure, Plotnicov, Pollice, Rao & McConaha, 2000). According to Ogden (2003), the way in which a genetic predisposition to anorexia manifests is unclear, but research shows a relationship with traits including obsessive compulsive disorder, perfectionism and body dissatisfaction (Treasure & Holland, 1995). The American Psychiatric Association (2005) reports new evidence in support of there being a relationship between eating disorders and genetics. However, they also stipulate that patients can be affected by the illness without a hereditary influence. According to Strober, Lampert, Morrell, Burroughs and Jacobs (1990), cases of males presenting with anorexia have increased among first and second degree relatives of patients also diagnosed with anorexia. Treasure and Holland (1991) carried out research using both monozygotic and dizygotic twins and their findings provided some support for the view that there is a genetic influence on anorexia. However, there is evidence to suggest that male anorexia is a more malignant form of the illness in comparison to female anorexia. This evidence would suggest that males suffering from anorexia may be more impacted by a greater number of genes or family environment causations compared with that of females (Strober, et al, 2000). It is important to note that research in the area of genetics and anorexia has largely concentrated on females and males may be underrepresented. Clusters of anorectics may also be influenced by the shared environments within which families exist.

The presence of family issues is reported to be a root cause contributing to the onset of male anorexia. Some psychoanalytic theories look at the function and significance of family relationships developed in childhood when discussing the root causes. Bruch (1985) suggests that the onset of anorexia may be attributed to a child trying to regain a feeling of power and control in a family in which they feel ineffectual. According to Bruch, this is typical in a family where a mother has been overbearing and smothering or where a child feels abandoned, neglected, continually criticised or misunderstood by other family members. An individual growing up in these types of family systems may not be able to express their feelings, having learnt to keep feelings hidden. With difficulties in emotional expression the individual may experience anorexia as a coping mechanism. Some research also suggests a link between attachment and the onset of anorexia. Many anorexics experience problems in dealing with their emotions and can be interpersonally dependent; theorists suggest a relationship between the emotional regulation processes and the object-seeking behaviours outlined in attachment theory. In attributing attachment difficulties to the onset of male anorexia, Koskina and Giovazolias (2010) specifically suggest that a fear of intimacy impacts males. However, there is relatively little information to understand the potential link between these attachment disorders and the traits associated with anorexia such as controlled eating patterns, low self esteem and body image concerns. Le Grange, Lock, Loeb and Nicholls (2010) tell us that adverse family environment factors can play a part in the onset and manifestation of anorexia but do not believe that family factors are the main causes of the eating disorder. They support the evidence that a combination of factors may need to be present for anorexia to occur in males.

Further research indicates that another contributing factor to the onset of male anorexia has been found in the brain's dopamine receptors, which regulate pleasure. When the body experiences a lack of food due to restrained eating, the brain dispenses feelings of euphoria. These euphoric feelings lead to an anti-depressant type of reaction which can have the effect of relieving anxieties. The American Journal of Psychiatry (2001) identifies the region of the brain called the anterior ventral striatum, linked to anxiety and perfectionism, and suggests a link to anorexia. The area of the brain called the caudate is also identified as impacting those with anorexia and is linked to obsessive thinking. Further research shows a link between genetics and early brain development, with trauma in early developmental stages being identified as a causation factor. Bailer and Kaye (2011) recommend deeper research into the neurobiology of eating disorders so that more effective and targeted therapies can be developed to treat anorexia and other eating disorders.

Evidence shows that, whilst there may be differences in the manifestation of male and female anorexia, there are many similarities in the underlying dynamics and needs of those suffering with the illness (Maine & Bunnell, 2008). It is because of these similarities that many theorists recommend similar strategies to be used in the identification and treatment of the disorder in both males and females. However, even though progress has been made in understanding and treating anorexia, there is still a concerning number of patients for whom treatment is ineffectual and who do not recover (Kaye, Strober, Stein, & Gendall, 1999). A multidisciplinary approach is therefore normally advised to address both medical and psychological issues. In a set

of published guidelines for eating disorders, the American Psychiatric Association advises a multidisciplinary approach with a combination of treatment modalities including psychotherapy, nutritional counselling, medical treatment, day hospital care, inpatient treatment and long term residential care (American Journal of Psychiatry, 2000). Anderson, Cohn, and Holbrook (2000), recommend a psychotherapeutic approach to treating the controlled eating and body image issues associated with male anorexia. They emphasise the importance of establishing trust and respect in the psychotherapeutic relationship. They also recommend empowering patients so that they can make their own decisions. Gore, Vander Wal and Thelen (2001) recommend three models for the treatment of anorexia; cognitive behavioural therapy, behavioural therapy and interpersonal therapy. Other therapies used in the treatment of anorexia include cognitive analytic therapy, group therapy and family therapy. Although treatment of male anorexia does not guarantee a sustained long term recover, research does show that combining treatments and addressing the issues as early as possible and ideally before the illness becomes entrenched contribute to a higher success rate.

In Conclusion, anorexia nervosa is considered to be a serious mental and behavioural disorder that can affect both males and females. With significant psychiatric and medical morbidity, anorexia is less prevalent in males compared to females, but is reported to be increasing. Research also suggests that male anorexia may be underestimated and further research into its prevalence is required. Complex in its origins, the onset of male anorexia is influenced by a number of factors and for each

individual suffering with the illness, there will be a different group of factors underlying and sustaining the disorder. Both medical and psychological issues underpin male anorexia and research has shown a multidisciplinary approach is required for treatment in order to attain a long-term recovery. Findings also show the need for further research to be carried out in order to provide effective treatments for this potentially deadly illness.

3 METHODOLOGY

3.1 Hypothesis

This study aims to investigate the prevalence of male anorexia in Ireland; to examine its manifestations and root causes and to explore why it is a growing concern in Ireland although less accepted than female anorexia. The study aims to identify and examine available treatment modalities in Ireland and to provide recommendations to address the idea that this male disorder is under diagnosed.

3.2 Introduction

Punch (2006) tells us that a descriptive study aims to; "collect, organise and summarise information about the matter being studied". This descriptive research project was designed to investigate and describe what currently exists in relation to male anorexia in Ireland; to organise the information identified in such a way that themes and patterns could be identified and a deeper understanding of the issues surrounding the illness could be gained. Through gaining a deeper understanding of the issues, this research project aims to propose recommendations for the field of psychotherapy in Ireland.

Qualitative research methods were utilised for the study with semi-structured interviews. A qualitative research strategy was chosen to allow the research to explore human behaviour. Walliman (2006) suggests that qualitative research is beneficial in that it allows for information to be conveyed and picked up through

language; through descriptions, opinions, feelings, emotions and explanations. The sample of participants chosen for the study were given the opportunity to express, with words, their views, opinions, understanding, knowledge and experiences in relation to male anorexia. According to Coolican (1999) a qualitative methodology can provide rich and subjective information.

An investigator-based semi-structure style of interview was adopted to ensure a compromise between a structured and unstructured format. According to Patton (2002) the main intention of an interview is to gain an understanding of the thought processes of the interviewee and to discover what is in their mind. A semi-structured interview allows the research to pursue points that are raised and information that is uncovered through the course of the research (Lee, 1999). Semi-structured interviews were carried out to gain an understanding of the experiences of practitioners working in the field of eating disorders, with specific experience of anorexia nervosa. Participants were encouraged to express their views and understandings and were not restricted with the facts and figures that a quantitative study would have produced. Not only did the qualitative method enable the identification and examination of views, experiences and understandings but also allowed comparisons to be made between participant responses; an opportunity that a quantitative study would not have allowed (Hair, Money, Samouel & Page, 2006).

3.3 Participants

Practitioners chosen to participate in this qualitative study currently specialise in the treatment of eating disorders and practise in eating disorder centres, general counselling centres or hospitals around Dublin. In order to gain views and information regarding both inpatients and outpatients, practitioners were identified from a mix of different centres and hospitals. This also ensured that any emerging themes exist across the board and can not be attributed to the ethos of a particular centre or hospital.

The purpose of the research was explained to each practitioner and an invitation was extended to participate in an interview. Confirmation was given that no specific client information would be requested and that participation would be anonymous. Five participant practitioners participated in the research study.

3.4 Materials

Each interview was carried out in a private room, in the counselling centre or hospital within which the practitioner works. Interviews were recorded using a dictaphone, in order to capture the whole discussion, with the consent of the participant. Each interview took between 1 and 1.5 hours and contained a list of 31 questions that were both open and closed. The questions related to male patients who had presented with anorexia, to the disorder and to treatment modalities. The questions were based upon themes identified in the literature review **(Appendix A)**.

Prior to each interview a consent form was discussed and signed by each participant **(Appendix B).**

Following the interviews a letter was sent to each participant, thanking them for their participation and reinforcing anonymity **(Appendix C).**

3.5 Ethical Considerations

When inviting practitioners to participate in this study, each was informed as to the nature and purpose of the study, why they had been chosen for participation and the potential length of the interview process. Each participant practitioner signed a consent form prior to the interview, allowing the content of their interview to be used for the purpose of a research thesis, intended for publication. The consent form outlined the purpose of the study, guaranteed their anonymity and that of their counselling centre or hospital and confirmed the secure holding of the thesis in the DBS library. Each participant practitioner was advised that they could view a copy of the recording of the study after the interview and could pull it from the study if they so wished. They were also advised that they could withdraw from the study at any time. (**Appendix B)**

3.6 Analysis

To analyse the data that was collected through questions raised and information gained, thematic content analysis was carried out. In order for the in depth qualitative analysis of data, each interview was transcribed verbatim. Themes and concepts were identified through the process of coding; coding units were identified with the purpose of simplifying and focusing on particular themes and information. According to Hair, Money, Samouel & Page (2006) the end result of coding is to; "enable the researcher to link data with topics, themes, concepts, ideas". The data was organised and reduced in order to make it manageable and understandable for the purpose of analysis.

3.7 Limitations

Male anorexia seems to be under-diagnosed in Ireland and a relatively small number of males seek treatment. Research into the area of male anorexia is limited in Ireland and internationally, as the illness is still predominantly considered to be a female illness. Practitioners, therefore, have a small sample set to base their findings on. Although the adoption of a qualitative research strategy presented a number of benefits including increased flexibility, it potentially restricted the research in terms of investigating the prevalence of the disorder (Lee, 1999). It also presented limitations in the validity and reliability of its data as the opinions, views, understandings, knowledge and experiences of the sample set were relied upon (Hair et al., 2006). In addition, many practitioners were reluctant to participate in the interview process due to their own time constraints. According to Schon (1987),

investigation, enquiry, evaluation and innovation are carrying increasing importance and acceptance with regards to human services professions, but time and energy for participation in research projects can be lacking. This appears to be a common limitation in the area of research.

4 FINDINGS

4.1 Prevalence of Male Anorexia

4.1.1 Number of Males Presenting

All participants acknowledged that statistical figures regarding the prevalence of male anorexia are under represented. The ratio of male to female cases is generally reported to be 10:1. However, participants reported a range from 8:1 to 5:1. One participant further differentiated by age; reporting the percentage of male patients presenting below the age of 15 to be as high as 25% of cases, and those above the age to be approximately 5% of cases.

All participants report an increase in presentation over the last 5 years, but it was noted that only inpatient records are used for statistical purposes, thus not accounting for those receiving other modes of treatment. Participant 3 reported increased requests to visit and educate schools with regards to male eating disorders; participant 5 reported an increase in enquiries from concerned mothers in the last 12 to 18 months.

4.1.2 Inpatient Figures

Participant 3 said 5% of cases are generally admitted to hospital for inpatient treatment and these would be acute cases. Another participant reported that the hospital within which they practice is currently collating numbers with regards to the

number of inpatients and was unable to give any current statistics. Two participants highlighted the lack of national statistics available regarding inpatient numbers and said hospital records do not accurately reflect the number of inpatients admitted with the illness, as many are recorded under a different primary diagnosis.

4.1.3 Misrepresentation of Figures

All participants report a misrepresentation of figures due to the issue of males not always seeking treatment. Participants also pointed to misdiagnosis of the illness in many cases as a reason for under representation of true figures. Participant 5 stated; "A lot of them don't realise they have an eating disorder. They are presenting with other issues, like depression or very low self esteem, body image issues, but they are not being diagnosed as having an eating disorder." Participants also concurred in their view that research in the area of male anorexia is scant and there is not enough data, for example, one participant said; "We don't have the data on the numbers of men with eating disorders and this perpetuates the idea that it isn't happening for young men or older men in fact".

Most participants discussed a greater awareness around the illness, but highlighted that many male anorexics are not seeking treatment. One participant said; "I don't think we have enough resources to diagnose it as early as it should be diagnosed. I don't think it is a bigger problem, I just think that more people are presenting". In general the view of participants was that the numbers of males presenting are

increasing but that prevalence has been an issue for some time. All agreed that there is insufficient data and more research is required.

All participants reported misconceptions, with the illness still widely considered to be a female adolescent illness and not one affecting males. Participants also reported that it is still considered to be a gay man's illness, although none of the participants reported higher numbers of gay men presenting in comparison to heterosexual men. 3 participants suggested gay men tend to be more interested in body image which could influence manifestation. All participants said these stigmas influence males seeking treatment.

Other reasons given for non presentation included denial, shame, embarrassment, fear of letting go of a coping mechanism, fear of what might come up and not understanding the illness or not seeing it as a problem.

4.1.4 Misdiagnosis

Participants also said national statistical figures are inaccurate because male anorexia is under-diagnosed. One participant stated; "I don't believe that GPs are identifying symptoms in male patients presenting with anorexia as much as they are in female patients, because it is an illness that is still associated with young girls. And the more research is focused specifically on young girls, the more that perception continues."

4.2 Gender Comparisons

4.2.1 Risk Factors

Participants reported risk factors to be similar across genders.

4.2.2 Manifestation

Participant 4 stated no difference in manifestation between genders, with all other participants reporting some similarities. In terms of calorie restriction, body weight, body image distortions and cognitive processes, they agreed similarities. Anorexia athletica, a classification of anorexia used to describe those who over exercise as a way of controlling weight, was reported by most to be more common in males than females, who were reported to be more likely to under eat. Participant 2 said; "males would be more prone to athletica. Like anorexia nervosa, it becomes entrenched and can be difficult to treat". Participant 3 stated; "There tends to be more of a focus, certainly at the pre-anorexia stage, on concerns around body image for young men. It's not that they're not restricting their diet, it's that their focus has shifted slightly more towards exercising." One participant reported anxiety and depression to be seen more in men.

4.2.3 Treatment

All participants agreed treatment modalities are similar across genders.

4.3 Ages at Risk

	Ages of Male Anorexic Patients
Participant 1	20's
Participant 2	20's
Participant 3	Below 10 to mid 20's
Participant 4	Late teens to early 20's
Participant 5	13 to 16

Males generally present for treatment from 13 to mid 20's, with one participant seeing patients under 10 but highlighting the danger zone to be from 16 to 18. Participants said the illness often goes unnoticed in males, resulting in the age of presentation to be later than that of females. One participant stated; "Men often don't present until they are in their 20's, it goes unnoticed….people wouldn't think of it, they might say, oh he's a fussy eater or he has a food phobia." However, all participants expressed difficulty in identifying accurate data due to the lack of males seeking treatment.

4.4 Root Causes

All participants agreed that each case of anorexia is individual and identified a combination of predisposing factors including: personality, developmental, sociocultural, family, genetic and environmental factors and experiences of trauma. Participants reported certain factors to be more dominant, including issues around

body image, low self esteem, low self worth and the effects of bullying or teasing, particularly about childhood obesity.

	personality factors	developmental factors	experiences of trauma	sociocultural factors	family factors	genetic factors	environmental factors
Participant 1	✓		✓	✓	✓		✓
Participant 2	✓		✓	✓	✓		✓
Participant 3	✓	✓	✓	✓	✓		✓
Participant 4	✓			✓			✓
Participant 5	✓	✓	✓	✓	✓	✓	✓

4.4.1 Personality Factors

All participants identified a connection between certain personality traits and manifestation, reporting a high comorbidity with perfectionists, high achievers and those with obsessive compulsive disorder, body image dissatisfaction, poor coping skills and a highly sensitive nature. Other traits identified include black and white thinking, depression issues, novelty seeking tendencies and rigid personalities. Participant 2 stated; “it’s tied to their emotional intelligence and their ability to deal with difficult emotions”.

4.4.2 Sociocultural Factors

Two participants stated all sociocultural backgrounds suffer from anorexia; another said, in her opinion, it is more prevalent in middle classes; while a third stated that it is more prevalent in higher classes. Two specifically stated that it is more prevalent in Western cultures, where there is a greater expectation to attain a particular body image. However, participants pointed to a lack of research in this area which has typically focused on the sociocultural influence on female anorexia. One participant said racial issues do not seem to have a direct influence on eating disorders.

4.4.2.1 Media and Body Image Pressures

All participants identified media and sociocultural pressures in Ireland to be influencers on the development of the male illness, citing pressure to be a certain body shape, size or weight as the main issue. One participant attributed the increase in male anorexia to media and sociocultural influences. Another stated; "I think the biggest concern that has been raised is around the shift in terms of how the world talks and looks at male bodies and the impact that's having on younger men in particular".

One participant said; "There is a connection between the images of men that are portrayed and male anorexia. People internalise those messages and behave accordingly. We are really seeing this in terms of the conversations we are having with young males about their bodies, how they feel about their bodies and the behaviours that come out of that". Participants identified the increasing number of advertisements, celebrity endorsements, brand products and male grooming agents

as having played a part in influencing male anorexia. One participant said; “The sheer number of images people see every day and the idea of a defined image for men is becoming more prevalent and this is having an effect.” In relation to the media and young Irish males, one participant stated; “it is putting up an image that can’t be obtained, which makes them uncertain of themselves”.

4.4.3 Family Factors

4.4.3.1 Learned Behaviours in a Family

One participant reported a higher risk of anorexia if a parent has an issue around food or weight control, as children are more likely to learn the behaviour. The same participant said an alcoholic parent can influence the development of the disorder.

4.4.3.2 Comorbidity with Early Childhood Attachments

Participants varied in their opinions with regards to anorexia and attachment. Two participants acknowledged that they lacked knowledge in this area, although one identified issues with attachment and female anorexia; another stated it was not significant in his opinion.

2 participants identified links between manifestation and early attachment deficits. One participant said insecure attachment or attachment issues pre-dispose a child to anorexia, where the child is so insecure and feels they need to control their body, due to feeling very out of control in the family environment. She quoted; “Insecure

attachment or any form of attachment, caused by, for example, neglect, can predispose a young male to an eating disorder… attachment disorders are very linked to eating disorders". The second participant said; "There is always something in families, they might not be very aware of it until you start uncovering layers".

4.4.3.3 Communication

Most participants identified poor communication in the family to be a factor that influences manifestation; in particular, families who do not talk about emotions or feelings, those who criticise each other, or families with over baring or controlling parents. One participant highlighted the way that conflict is managed as a factor

4.4.4 Experiences of Trauma

Most participants agreed traumatic events can predispose a male to anorexia, including abuse, rape, neglect, family breakdowns and separations and bullying.

4.4.5 Genetic Factors

Participant 2 said, in her opinions, genetic factors are not at the root of the illness. All other participants acknowledged that further research in the area of genetics and anorexia is required. Two participants were aware of research currently being undertaken; one reported; "They are looking at specific chromosomes now that are associated with very restrictive anorexia." One stated; "there is research to say that the way we think, feel and behave is actually changing our DNA" and reported a

higher likelihood of an individual developing anorexia if a parent, aunt, uncle, grandmother or grandfather has a problem. She also acknowledged this could be attributed to learned behaviour. One participant stated; "If you're born with low serotonin, you're more likely to be impulsive. And if you're born with low endorphins, you're more likely to have an addiction or low self esteem. So, biochemically the vulnerability is there and then you have issues like environmental, cultural, trauma, developmental, personality issues that then fit into place like a jigsaw."

4.4.6 Environmental Factors

4.4.6.1 Peer Pressure

4 out of 5 participants said peer pressure influences the onset of the illness. Pressure identified includes competition and pressure to look a certain way both in body shape and image.

4.4.6.2 Bullying and Teasing

One stated; "Bullying is a negative peer influence that can impact the development of an eating disorder. It would be common for males who have an eating disorder to have been bullied". In her opinion, 70% of people presenting have experienced some kind of bullying or criticism. Participant 4 concurred with this view highlighting teasing and bullying to be most prevalent factors in late primary school. One participant said males are influenced by peers, particularly in relation to exercise and

body building. Participant 3 said groups of males often form and engage in unhealthy habits like visiting the gym excessively and obsessively.

4.4.6.3 Participation in Occupations, Sports, Hobbies

4 out of 5 participants reported particular occupations, sports and hobbies to influence the disorder. All 4 participants identified a higher likelihood that males in weight sensitive professions and those participating in sports or hobbies that require a particular body weight, size or shape could develop unhealthy eating practices and excessive exercise routines. One participant highlighted a link with emotions and poor coping skills.

Professions specifically identified include:	Sports and hobbies specifically identified include:
Dancer	Boxer
Jockey	Jockey
Model	Rugby player
Actor	Runner
Gym instructor	Body builder
Personal trainer	

4.4.7 Developmental Factors

Participant 5 related developmental factors to male anorexia. She reported puberty to be a time when adolescents are more vulnerable to eating disorders and stated; "they get more muscular, which lends itself to the body image of the muscular man

that they tend to want to be". Participant 4 said some patients experience a combination of bullying, teasing and body image difficulties around puberty which influences manifestation.

4.5 Treatment

4.5.1 Multi-discipline Approach

Participants agreed treatment depends on each individual case; on the combination of factors, issues presenting and severity. All recommend a multi-disciplinary approach in order to effectively treat the emotional mental and physical health of the patient.

All participants recommended family involvement in treatment. Participant 5 highlighted how this can sometimes be an issue with inpatient treatment, as patients sometimes have to seek treatment abroad due to the lack of hospital beds and long waiting lists in Ireland. Participant 4 said treatment should initially involve a family doctor, but if the situation deteriorates significantly, a specialised eating disorder unit would be necessary. He said; "Our hospital offers a holistic, multi-disciplinary programme with family intervention".

The Range of treatment modalities Identified Include:
General Medical Care
Psychiatry
Psychotherapy
Cognitive Behavioural Therapy
Interpersonal Therapy
Family Therapy
Motivational Therapy
Nutritional Management
Nutritional Counselling
Medication

3 participants said specialists from different approaches need to work more effectively together. One stated; "Practitioners and doctors may not always appreciate each other's role in the treatment process. Some psychiatrists, doctors and psychotherapists work well together in the treatment of anorexia, others don't". Participant 3 said psychotherapy and physical mental health are completely entwined and treatment needs to recognise this. Another participant said; "males don't always know they have an eating disorder and are presenting with depression, low self esteem and body image issues, for example. As a result, they are often misdiagnosed. More information is required for psychotherapists."

4.5.2 Inpatient Treatment

Most recommend inpatient treatment for acute cases. Participant 3 said; “Inpatient treatment in Ireland tends to focus on physical health but ultimately your concern is in dealing with the emotional background to it”. Participant 2 recommended a systemic model and stated; “I do not believe the best treatment is the inpatient treatment model, it’s an outdated model. We are very poor on inpatient treatments in Ireland….often counselling is not included in treatment… the main focus is to re-feed them in hospital, obviously they need food but it’s not the main focus, they need counselling to address the underlying emotional issues”.

2 participants emphasised the importance of continuity of care after inpatient treatment and criticised the current absence of after care and counselling.

4.5.3 Accessibility of Treatment

Only one participant said treatment is very accessible, with most participants acknowledging a lack of specifically trained counsellors and GPs and limited inpatient facilities. Participants highlighted that inexperienced GPs often misdiagnose male anorexia or refer patients down the psychiatric root and not to specialised practitioners or psychotherapists.

One participant said inpatient treatment is not always available; with only 3 publicly funded beds in Ireland, restricted to people living in Dublin and North Leinster region.

Two participants discussed referring acute cases abroad, where treatment is more advanced but acknowledged this presents issues with family involvement and aftercare. Three participants highlighted poor marketing of available treatments to male anorexics and Participant 4 acknowledged a lack of male practitioners with specific knowledge in the field.

4.5.4 Likelihood of Recovery if Treatment is Sought

All participants said the likelihood of recovery is good, if treatment is sought. One participant reported the likelihood to be 4/5; another reported 8/10. Participant 3 said; "40% recover, 40% have some level of recover and 20% don't recover". Participants agreed that the younger the patient is and the earlier that treatment is sought, the better the chance is of recovery. Participants agreed that if underlying issues are not addressed through treatment, the illness can become more entrenched. One participant stated; "Once the eating disorder becomes entrenched, then you're fighting a battle against a strongly entrenched set of beliefs and behaviours. You're also dealing with much more serious physical consequences".

All participants agreed that more available information is required for potential sufferers.

4.5.5 Mortality

4 participants expressed a concern about the mortality rate of patients, for whom treatment is not successful. Participant 3 said the mortality rate is 20% and sometimes higher, with high rates of suicide; Participant 4 said that 1/5 cases are fatal.

Two participants identified discrepancies in the recorded numbers of fatalities as deaths are often attributed to other causes, including heart failure and suicide. One participant stated; “The Department of Health report 80 deaths a year to anorexia, but in my opinion the number is actually higher”.

4.6 Recommendations to Change the Stigma

Participants stressed the need to raise awareness particularly through education, through more training for therapists and through building a greater understanding amongst practitioners. 3 participants highlighted the need for GPs to have specific training so that they can better diagnose the illness.

Most participants stressed the need to communicate to potential sufferers that many other males have the problem, that it is a coping mechanism and to raise awareness of available treatments.

Generally participants recommend better marketing of the male illness and treatments available; participant 2 acknowledged that their marketing material does not specify that treatment is available for male sufferers and intended to rectify this issue following the interview. Another participant criticised poor marketing of the male illness, with marketing being targeted to young females, despite including menstrual problems as the second implication of the illness in their marketing material.

One participant said the stigma that sufferers are manipulative and cunning needs to be dealt with and stressed it is the illness that is manipulative and not the patient.

4.7 Future Approaches

All participants said better information is required to raise awareness and inform people about the illness; 2 participants suggested giving clear information through mental health campaigns. Three participants said male anorexia needs to be spoken about as an illness that can affect anyone, not just young females or gay males; through changes in media perceptions and communications. All participants agreed that more research is required.

Two participants identified a problem with practitioners attempting to treat the disorder without specific training or understanding of what is required; they recommend specific training for all counsellors, therapists and GPs. Participant 5

stressed the importance of having specific training in the treatment of anorexia, particularly as the mortality rate is 20%, and said; “There’s a huge lack of knowledge and therapists who aren’t trained in this area make huge mistakes; more so for people presenting with weight loss. There are a high number of therapists who don’t have an understanding of eating disorders”.

5 DISCUSSION

This study set out to explore whether the reported rise in the presentation of male anorexia in Ireland reflects an actual increase in the number of those with the illness. It also set out to explore gender comparisons and root causes and to examine the accessibility of and recommendations for treatment. What follows is an analysis of the findings in relation to relevant literature.

The view of the practitioners referenced in this study is that anorexia is more common among males than statistics illustrate. The American Psychiatric Association (1994) report that anorexia affects 1 male to every 10 females. However, research findings indicate that the figure is higher, which is consistent with Anderson (2002) who argues that the ratio is closer to 1 in 6. Irish practitioners report an increase in the presentation of male anorexia over the last 5 years, which implies that there has been an increase in the number of cases presenting since 2006. While practitioners agree that there has been an increase in the presentation of male anorexia, the majority of those interviewed believe the increase is due, not to a significant increase in the prevalence of the illness among the male population in Ireland, but to higher numbers of males presenting for treatment. A lack of publicly available and comparable data on the prevalence of the male illness makes it difficult to validate this professional consensus in Ireland, as has been shown to be the case internationally (Braun et al, 1999).

There are 4 factors which might lead to the misrepresentation of available statistics with regards to prevalence: (1) statistics only represent inpatient records, (2) inpatient records do not accurately reflect the number of males admitted with the illness, (3) there are a number of misconceptions about male anorexia that prevent many males from seeking treatment and (4) cases of male anorexia are often misdiagnosed.

Only patients admitted to hospital with male anorexia are recorded and quoted for statistical purposes and implies that those treated through other modalities are not taken into account. Of those cases admitted, many are recorded with a different primary diagnosis, implying a misrepresentation of actual figures. This means that figures are under representative of the prevalence of the illness. This is consistent with Zhao and Encinosa (2009), who report a significant increase in inpatient admissions in the United States but argue that the statistics are an inaccurate representation of the hospitalisation of males with eating disorders. A larger study would be necessary to provide robust statistical evidence of the prevalence of male anorexia in Ireland.

Findings show that many male sufferers do not seek treatment and suggest that this contributes to the prevalence of the disorder being underestimated. These findings are consistent with Hudson et al (2006) whose published survey suggests that statistics may underestimate the prevalence due to the unwillingness of men to come forward and seek treatment. Practitioners attribute this unwillingness to

misconceptions and stigmas that anorexia is a female problem or a gay problem, concurring with research by Whelan (2002). Participants identified that many male sufferers do not present for treatment due to the stigma attached to the illness; it is still widely believed that anorexia only affects adolescent females and gay men. Lucas et al (1991) and Sharp et al (1994) report gay men to account for 5-10% of sufferers and show an increase in the numbers presenting with the illness. However, there were no findings in this study to support the idea that more homosexual men present in comparison to heterosexual men. Participants did suggest that gay men may be more susceptible to pressures to conform to a particular body image and indeed research shows that gay men are particularly vulnerable to the impact of the media and peer group influence (Morgan and Arcelus, 2009; Connor et al, 2004).

It is the general belief of the professionals who participated in the study that misdiagnosis of the male illness is also a contributing factor to the disproportionate statistics of males presenting; a view supported by Schneider and Agras (1987). Findings suggest that many GPs and counsellors lack specific training to adequately treat the male illness, which is consistent with Whelan (2002); Whelan identifies a lack of awareness with some health professionals as to the fact that anorexia can affect men.

Data shows males presenting later than females; from below the age of 10 years and into the 20's. Some practitioners highlighted a later onset of the illness in comparison to females. Sacker and Zimmer (1987) also found that the onset of illness

occurs in males before the age of 25 and that it can remain entrenched beyond the age of 30. Abraham and Llewellyn (1999) also report the onset of anorexia to normally occur later in males and attribute this to being involved in an occupation or sport in which weight control influences performance.

The findings of this study qualitatively suggest that male and female anorexia are similar in manifestation, course, comorbid psychopathology, risk factors and treatment modalities. This is consistent with the best available research in the field (Braun et al, 1999). However, results of the study imply some notable differences in manifestation. The evidence available suggests that in addition to anorexia nervosa, anorexia athletica is a predominant manifestation for male sufferers in Ireland. This form of anorexia manifests itself through obsessive and excessive exercise as a way to control weight. In comparison female sufferers are more likely to control weight through under eating. Findings also imply that the manifestation of male anorexia is more likely to present through anxiety, depression and black and white thinking, than with the female illness. A larger study is necessary to further investigate a correlation between gender and manifestations of the illness.

The results of this study show that each case of anorexia is individual and a combination of predisposing factors normally exist. This is consistent with research carried out by Le Grange et al (2010), which evidences the existence of a combination of factors for male anorexia to occur. The range of root causes identified by this

study include: personality, developmental, sociocultural, family, genetic and environmental factors and experiences of trauma.

The experience of Irish practitioners reflects that certain predisposing factors are more commonly seen in the combination of factors presenting in male sufferers. As presented by Whelan (2002), findings of this study identify a high comorbidity with male anorexia and particular personality traits. These traits include: obsessive compulsive disorder, an obsession with body image, body dissatisfaction, a tendency towards perfectionism, a tendency towards high achievement, low self esteem, and those with a rigid personality or highly sensitive nature. The American Journal of Psychiatry (2001) provides biological research in support of the findings that there is a high comorbidity with male anorexia and obsessive thinking, perfectionism and anxiety.

With regards to comorbidity with sociocultural factors, the study does not provide sufficient findings to support that male anorexia is linked to class or race, but participants in this study did suggest a higher prevalence in Western cultures, which is consistent with Hsu and Lee (1993). They argue that Western cultures typically desire a particular body image, causing anorexia to be more prominent. However, it is notable that available research in this area has typically focused on female anorexia and further research is required to understand the trends in relation to male anorexia in Western cultures. Grogan (2008) argues that boys are under increasing pressure in society to conform to a particular body image and the findings of this study concur

with this view; practitioners cited societal pressures to attain a certain body shape, size or weight to be an underlying cause of the male illness. A report by McNicholas et al (2009) highlights the influence of the media on the perspectives of young Irish people, who feel adversely affected by unrealistic representations of an ideal body image, and this is certainly consistent with the findings of this study. Practitioners pointed to this predisposing factor as the most concerning in terms of its increasing impact on the illness; a view that is supported by Grogan (2008). Further research would need to be undertaken to understand the relationship of the ideal body image portrayed by the media and the prevalence of male anorexia; this concurs with O'Drea and Yager (2006), who argue that there is not enough research on the correlation between body image, dieting, and eating behaviours in the male population.

Family factors that can underlie male anorexia, according to the findings of this study, include learned behaviours, poor communication and early childhood attachment issues. Grange et al (2010) present findings to relate adverse family environment factors to the onset of anorexia. Participants in this study specifically highlighted poor coping skills and emotional intelligence as influencing factors, often seen to present with other family factors; research shows a relationship between the emotional regulation processes and the object-seeking behaviours of attachment theory (Bruch, 1985). With regards to the influence of genetic and development factors on the manifestation of male anorexia, the findings show mixed results, and highlight that further research is required in this area.

Environmental factors identified by this study as predisposing factors of male anorexia include peer pressure, bullying and teasing, and participation in certain occupations, sports and hobbies. A report by Braun et al (1999) also suggests that involvement in certain professions, sporting activities and hobbies can influence the manifestation of male anorexia, in conjunction with dysfunctional eating. Experiences of trauma were also found to be predisposing factors of male anorexia.

The findings of this study and research in this area show similar strategies for the identification and treatment of anorexia across genders. Findings and research recommend a multidisciplinary approach that combines a number of therapies, treatments and supports, to effectively treat the emotional and physical health of patients and to sustain a long term recovery (American Journal of Psychiatry, 2000). Psychotherapy is reported to be effective in the treatment of the emotional aspects of the illness but this study and research shows it is most effective as part of a holistic treatment plan (Gore et al, 2001).

However, practitioners in this study put forward a view that many healthcare professionals in Ireland are not effectively working together to provide a robust and consistent multidisciplinary approach. Participants also argued that many psychotherapists, counsellors, GP's and other healthcare professionals in Ireland are inadequately trained with regards to identifying and treating anorexia, with some

practitioners attempting to treat the disorder without specific training or understanding of what is required. Further research in these areas would be required in order to support these views. Inpatient facilities for anorexic patients are limited in Ireland and the study shows evidence of some patients being referred abroad to get treatment. Participants in the study also presented arguments to show a lack of awareness in Ireland that anorexia can affect males and highlighted poor marketing of treatment services to male sufferers. A larger study into this area would be required to investigate the extent and impact of these issues.

Statistics show anorexia to have the highest mortality rate of any psychiatric disorder (Attia, 2010). The Department of Health in Ireland estimate that 80 cases end in fatality a year. Findings support the evidence that some patients do not recover, but argue the actual and unreported figure to be higher due to many deaths caused by anorexia being attributed to other causes. Although Kaye et al (1999) provide evidence in line with the findings that a concerning number of patients do not recover; further research is required in this area to substantiate these findings.

6 CONCLUSION

In conclusion, this study shows that male anorexia is a complex illness and a growing concern in Ireland that requires greater awareness, attention and education. Findings clearly show that anorexia can no longer be considered a female illness and must be taken seriously. Although research does not clearly evidence an increase in prevalence, it does evidence an increase in presentation, suggesting that more men are coming forward and seeking treatment. With more men seeking treatment, it is the recommendation of this study that psychotherapists are given specific training to ensure their ability to identify, provide or ensure appropriate treatment. Once male anorexia becomes entrenched, it can be difficult to treat. Therefore, the early identification of the many manifestations, an understanding of the underlying causes, and knowledge of available combinations of treatment for cases of male anorexia are essential to sustain long term recovery for sufferers.

This study shows that greater awareness and education about male anorexia is required in Ireland. It is a recommendation of this study that colleges and universities provide specific training to students of psychotherapy. In particular, this study recommends that Dublin Business School incorporate a one day workshop on anorexia into the curriculum for the undergraduate study of counselling and psychotherapy. The Eating Disorder Resource Centre of Ireland specifically requested to be named in this study as available to provide such a workshop.

It is also a recommendation of this study that psychotherapy centres consider their marketing and communication tools in relation to anorexia. Treatment is widely advertised for anorexia, but few centres advertise specific treatment for male sufferers. In order to breakdown the stigmas associated with this potentially deadly illness, greater efforts need to be made to increase awareness about the illness and the availability of treatments and support services for males in Ireland.

The full extent and impact of male anorexia is still unknown with little research in the area. The results of this study provide evidence that greater research into the many aspects of male anorexia is required to fully understand the prevalence, root causes and manifestations of the illness and to fully realise the impact and implications of the illness on the male population in Ireland and internationally.

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8 APPENDICES

Appendix A- Interview Questions

INTERVIEW QUESTIONS

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1. In your opinion, what is the ratio of male to female patients seeking treatment?
2. What ages do men tend to present with anorexia?
3. Do males present with different symptoms?
4. What would you say are the causes of male anorexia?
5. Is there a gender difference in the manifestation of anorexia?
6. Have you noticed particular root causes that are more prevalent in men?
7. Is there any one dominant underlying problem or do combinations of root causes present in male anorexics?
8. Are you concerned about the mortality rate of patients, for whom treatment is not successful?
9. Do you notice certain traits in male anorexics?
10. Are male anorexics most likely to lose weight, desire a different body shape or have an obsession with building bulk/muscle?
11. What influence do you think the media has on male anorexia?

12. Is there a particular magazine, TV programme, image, magazine, brand etc that is currently influencing most male anorexics?

13. Does playing a particular sport or participating in a particular hobby or job influence the onset of eating disorders in your male patients?

14. Does sociocultural background influence the disorder in your male patients?

15. Do you have a higher percentage of males presenting than you did 5 years ago?

    - If yes – did you notice a rise in male presentation?

16. Do you think it is attributed to any particular causes?

17. Have you noticed a higher proportion of homosexual men compared to heterosexual males presenting with anorexia?

18. How often do failures in early childhood attachments present when treating male anorexia?

19. Do you treat male anorexics who present with a genetic root cause?

20. Do you think the family environment influences the onset of male anorexia?

21. Do you think there is pressure from peers?

22. Do you think there are many male anorexics that have the illness but do not seek treatment?

23. Why do you think they avoid seeking treatment?

24. What do you think might make it easier or less of a stigma for men to come forward?

25. What is the likelihood of recovery if treatment is sought?

26. Does it make a difference if patients delay in seeking treatment?

27. What kind of treatment is recommended for treating male anorexia?

28. How accessible do you think treatment is for young males?

29. How might information be given?

30. How many of your patients are admitted to hospital?

31. Do you think there should be a shift in thinking with regards to the treatment of male anorexia? A different approach?

Appendix B – Interview Consent Form

RESEARCH PROJECT

INTERVIEW CONSENT FORM

Thank you for considering participating in this research project

Male anorexia is a growing concern but is less widely accepted than female anorexia. The aim of this research is explore the root causes leading to male anorexia, to gain a greater understanding of its prevalence, why it is reported to be increasing but may be under diagnosed. It is also hoped that this research project will raise awareness of the effectiveness of treatments for the disorder.

In this project your anonymity will be guaranteed; accordingly your name and the name of your counselling centre will not be shared. You may withdraw at any time from participation, in which case any information you have provided will not be used for the purpose of this project. The completed research project will be submitted to Dublin Business School, where it may be held in the library for reference.

If you agree to participate please sign your consent below:

I understand that my anonymity is guaranteed

I understand that I can withdraw at any time and request that the details of the interview are not used for the purpose of this research

I hereby give consent to conduct this interview

Signed……...

Date ……..

Appendix C – Thank you Letter to Participants

First Name Surname

Address 1

Address 2

Address 3

Date

Dear *First Name*

Thank you for meeting me and taking the time to participate in my research on male anorexia.

I enjoyed talking to you and greatly appreciate your contribution to my thesis and the time and information that you gave.

With kind regards

Dinah Lawrence