The Unique Experience of Eating Disorders within the Male Population: A Review of Existing Stigma, Knowledge Gaps, and Gender Bias within their Recognition, Diagnosis, and Treatment

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The present study synthesizes the recent research related to the experiences of males who struggle with eating disorders. Three universal themes emerged: first, a blame-based stigma surrounding eating disorders, specifically in the male population; second, a lack of education within the male population regarding the pathologies and treatment options available for those suffering from eating disorders; third, significant gender bias in the treatment of eating disorders, particularly among the assessment tools used to diagnose them. Early findings suggest that specific focus on the biological and genetic factors of eating disorders seems to be the best method to reduce blame based stigma. In addition, the most practical way to counteract the gender bias exhibited by assessment tools is the development and popularization of male specific eating disorder assessments.

For many years, within both professional and popular psychology, the commonly repeated yet uncited statistic was that one in every ten cases of eating disorders occurred within a male, and despite the origin of this figure being unscientific at best, it was frequently seen as a fairly reasonable estimate for the frequency of eating disorders within the male population (Cohn et al., 2016). However, a landmark study published in 2007 suggested that when speaking about anorexia nervosa and bulimia nervosa, a more accurate statistic for their prevalence within men is actually closer to 1 in 4, and when speaking of binge eating disorder, closer to 1 in 3 (Hudson et al., 2007). Since the publication of this study, a great deal of research has been conducted seeking to understand the unique experiences of men who suffer from eating disorders. Given that many of their experiences are centered around that which is difficult to numerically quantify, much of this research has been conducted by carrying out qualitative, in-depth interviews with men suffering from these conditions and then seeking to identify common themes (Lyons et al., 2019; Räisänen & Hunt, 2014; Robinson et al., 2013; Siegel & Sawyer, 2019).

After analyzing these studies, there seems to be three common themes that surfaced throughout. The first is an increased stigma surrounding eating disorders as compared to other mental health disorders, specifically when occurring within the male population. This stigma seems to largely result from the belief that eating disorders are a characteristically feminine disorder, and thus suffering from one often causes the victim to be perceived as less masculine. Much research has been done regarding how to best counter mental health stigma in general and how to more precisely address the stigma associated with eating disorders, systematically analyzed in Corrigan et al. (2012) and Doley et al. (2017) respectively; however, only a minor percentage of this research has specifically studied the male population. Secondly, there seems to exist a general lack of education within the male population regarding eating disorders (Räisänen & Hunt, 2014). Although further research is needed on the subject, some of the preliminary findings of recent research suggest that among the adolescent population, increasing education could not only counter this ignorance, but simultaneously serve as the most effective method of reducing stigma (Corrigan et al., 2012). Finally, there exists significant implicit gender bias in the treatment of eating disorders, particularly among the assessment tools that allow clinicians to recognize their presence (Darcy et al., 2012). For this reason, the psychological community must advocate for further development and incorporation of male specific eating disorder assessments. Therefore, the increased stigma and general lack of understanding surrounding eating disorders specifically occurring within the male population can best be counteracted through increased educational efforts. Alongside this, further development and familiarization of gender specific eating disorder assessments among treatment providers has the potential to both more accurately diagnose and provide validation for males struggling with eating disorders.

The first common experience identified by men throughout multiple studies was the experience of increased mental health stigma related to eating disorders. Even prior to discussing those occurring specifically within the male population, there seems to exist an increased stigma surrounding eating disorders when compared with other mental health disorders. Although stigma is a term

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that is best defined operationally, and is thus difficult to attribute to any single factor, one study indicated a significant difference between the public's understanding of eating disorders when compared to their understanding of other mental health disorders. Much of this stigma appears to result from a public perception of eating disorders as being a "feminine" disorder, and thus they have the potential for the victim to be viewed as less masculine. However, blame-based stigma seems to be a compounding factor. Analyzing the results of two nationwide surveys across the United Kingdom related to public understanding of mental health disorders, Crisp (2005) noted that other than alcohol and drug addiction, participants were most likely to view eating disorders as self-inflicted. Although it should be emphasized that mental health disorders are never the fault of the person suffering from them, this evidence suggests that this needs to be particularly emphasized in relation to eating disorders. This study did not indicate that the perception that eating disorders are self-inflicted as more applicable to one gender or the other, however, given that self-reliance and independence are highly valued traits among men in Western culture, it can be understood how men would generally be more hesitant than women to openly discuss or seek treatment for a disorder they felt as though they had brought upon themselves. Testimonial evidence suggests that this increased stigma surrounding eating disorders does in fact impact males. A participant in one qualitative interview study related to the experience of men with eating disorders in the workplace described that he had disclosed to his employer and even made arrangements for special accommodations related to his bipolar diagnosis, however, he had not taken similar steps related to his eating disorder diagnosis (Siegel & Sawyer, 2019). This demonstrates that even among men who are willing to discuss other mental health disorders, eating disorders seem to occupy a separate sphere. Subsequent research regarding the nature of factors that affect an individual's likelihood of seeking treatment for an eating disorder has also confirmed that the perception of eating disorders being self-inflicted seems to have a greater impact on males than females. One study found that among participants from the United States, United Kingdom, and Australia, "the association between self-stigma of seeking psychological help and increased likelihood of having an undiagnosed eating disorder was stronger for males than for females." The authors of the study continued to explain that their findings were "consistent with the view that males with eating disorders are more reluctant to seek treatment than females, hence more likely to be undiagnosed, and that perceived stigma associated with help-seeking may be a factor in this" (Griffiths et al., 2015).

Another contributing factor to the stigma surrounding eating disorders within the male population identified by multiple men was the common portrayal of eating disorders being something that affected what one participant described as "fragile, teenage girls who are very emotional" (Räisänen & Hunt, 2014). When discussing the media coverage of eating disorders, men frequently expressed feelings of invisibility. Commenting on this portrayal, one interviewee stated, "What [you] see in the papers is young girls trying to get themselves down to size zero. Do you ever read about men trying to do that? I don't" (Robinson et al., 2013). Although the portrayal of eating disorders as being a predominantly female issue is correct, the portrayal of eating disorders as an exclusively female issue is most certainly incorrect, considering Hudson et al. (2007) findings that between one third and one quarter of eating disorders occur within males. The detrimental effects of the media's tendency towards the prior depiction was evident throughout a number of studies and led many men to feelings of extreme isolation. The interviewee who most clearly summarized this stated that "I felt 'I'm the only guy in the world this has happened to'. So it can be quite an isolating thought… 'no other guys have had this problem. What's wrong with me? Why have I succumbed to this if no-one else has?'" (Robinson et al., 2013). These feelings of isolation seemed to only be compounded by an unspoken emphasis of stoicism unique to the male experience. When comparing the experience of men with eating disorders to that of females, one interviewee stated, "there's different experiences for men because, you know, 'No I don't get ill, I'm a man'. You know, 'I don't get ill, don't need treatment, I don't have emotions.'" (Räisänen & Hunt, 2014).This aversion to publicly exhibiting emotions also demonstrated itself among men in a common fear of gender related judgement if they were to seek help. When considering the hypothetical of how things would be different if he were a female, another interviewee stated, "if I were a girl, I would have people I could go talk to. As a guy, you do not really have that option without people judging you too hard" (Siegel & Sawyer, 2019). Although the assumption that women do not also suffer from the increased stigma of eating disorders is untrue, statements such as this illustrate that many men feel as though they are suffering from an exclusively "feminine" disorder. In sum, the male experience of eating disorders seems to universally entail the experience of greater stigma based on one's gender while suffering from

a psychological disorder that already subjects its victims to increased stigma when compared to other mental health disorders. Perhaps resulting from a perception of eating disorders as being a self-inflicted wound, this stigma manifested itself in a significantly greater hesitation to seek treatment and a general sense of invisibility. In turn, this seemed to deepen men's perception of the necessity of qualities such as self-reliance, independence, and stoicism and led many to feelings of extreme isolation.

The second common theme numerous men identified as presenting a barrier to identifying their illness was insufficient knowledge of eating disorders. Among these interviews, there emerged startling evidence of widespread ignorance among men, particularly related to the pathologies of eating disorders, that undoubtedly prevented multiple interviewees from identifying their eating disorder earlier. Räisänen and Hunt (2014) described that in their study, one participant "had never heard of [Bulimia Nervosa] and thought bingeing and purging was something he had 'made up.'" The fact that this participant, who was twenty five years old at the time he gave the interview, had not only never heard of bulimia, but also never heard that bingeing and purging are perhaps the most obvious indicators of disordered eating, might seem unthinkable to many within the psychological community. However, further testimony suggests that this ignorance related to eating disorders more accurately represents the general lack of understanding that exists within the male population than the psychological community would like to believe. In the same study, another participant stated, "I didn't know men could get eating disorders… I didn't know the symptoms, didn't know anything, it was just, to me it was just happening. I didn't really know what was going on" (Räisänen and Hunt 2014). Although it is unclear whether the statement "I didn't know men could get eating disorders" demonstrates a distorted perception of the frequency of eating disorders within the male population or a genuine belief that eating disorders are a gender exclusive illness, under either circumstance this participant, similarly to the previous one, clearly identified his lack of knowledge of the pathologies of eating disorders as a major factor in preventing him from identifying his illness. In addition, even though there exist certain shared pathologies of eating disorders among males and females, there is the potential for certain differences, primarily in that there exists a significantly greater variety of motivating factors for eating disorders among men than simply becoming thin. Although not specifically expressing how his experience differed from what he had heard of females who struggled from eating disorders, a third participant stated, "I didn't really know what, where to go or what to do to be honest. We've all heard of the like female anorexia and all of that… [but] that isn't what I was going through" (Räisänen & Hunt, 2014). This general lack of understanding related to the pathologies, prevalence, and gender specific experience of eating disorders caused many men significant delay in the identification of their eating disorders. This is particularly noteworthy given that early diagnosis and intervention has significant potential to improve prognosis.

The third shared experience numerous men discussed was the existence of implicit gender bias within the treatment of eating disorders, ranging from the facilities they are treated in to the assessment tools used to measure them. The authors of one qualitative study briefly described some of the manners in which those they interviewed experienced gender bias. Lyons et al. (2019) writes, "One man experienced official health communications which referred to him using female pronouns, while a number of the men commented on being given worksheets and questions tailored to females." They continue, "[another] man had a period of in-patient treatment [in] a specialized unit, which had a female and disabled toilet, but no facilities for men." It is understandable how many would simply disregard these factors as minor practical difficulties: after all, are these men not capable of simply substituting the appropriate pronouns or using the handicap facilities? Lyons et al. (2019) however, emphasizes how devastating a mistake this could prove, stating that "concerns over existent gender bias with regard to treatment is an important issue, as the prognosis for men may be compromised if the health care they receive has the potential to further emasculate them." It has previously been established that many men with eating disorders already struggle with both a self and social perception that they are struggling with an adolescent girl's issue. When those men finally find themselves reaching out to receive professional help, if even the facilities and tools being used by treatment providers echo this cultural stereotype, there exists the very real possibility that these men will only further internalize the misconception that they are the only male struggling, which has the potential to lead to an even greater sense of isolation.

However, perhaps even more devastating than the implicit gender bias that many men experience once they begin the treatment process is the gender bias that exists among the tools used to initially diagnose eating disorders. Shortly after its development in 1987, the Eating Disorder Examination (EDE) became recognized as the gold standard used by clinicians to determine whether a client is

suffering from an eating disorder. Administered in a semi-structured interview, the EDE measures the relative frequency of certain behaviors that are known to suggest the presence of an eating disorder over the previous twenty-eight days. However, recently the infallibility of the EDE has been called into question. In a study comparing the respective EDE scores of males and females with similar clinical presentations, Darcy et al. (2012) found that men tended to score significantly lower on a number of individual items, two of the four sub-scales, and the overall score. The authors of the study continue to suggest that although males tended to score significantly lower than their female counterparts demonstrating similar clinical presentations, the ability of the EDE to detect the presence of eating disorders within the male population was not compromised, and could even be significantly improved if the evaluator omitted specific questions.

Although I agree that assessments such as the EDE are both reliable and valid measures capable of identifying the existence of eating disorders within both genders, I believe they have the potential to lead to a number of complications that suggest the development of gender specific assessments provides a better alternative. First of all, given that the EDE has been historically viewed as a gender neutral tool, there does not exist any formal criteria for which questions are to be omitted when being administered to a male versus a female. Therefore, a client who received the EDE from one clinician who chose to omit those items suggested by Darcy et al. (2012) could potentially receive a different score from a clinician who included them. In addition, the questions which the authors of this study indicate ought to be omitted are not replaced with questions specifically related to male concerns, they are simply dropped. This decrease in both the number and specificity of questions could potentially cause further score distortion that has not yet been identified. Finally, there exist other popular methods of measuring eating disorders not analyzed in Darcy et al. (2012) that also exhibit significant gender bias. Cohn et al. (2016) identify how another popular assessment, the Eating Disorders Inventory (EDI), has the potential to exhibit gender bias. The EDI asks subjects to either agree or disagree with a series of statements, indicating an increased or decreased likelihood of possessing an eating disorder respectively. Cohn et al. (2016) identify one such statement, "I think my thighs are too large," as potentially being more applicable to females than to males. However, not only does this statement have the potential to be more applicable to females than males, under certain circumstances it actually has the potential to measure in the opposite direction. For females, given that the primary motivation for the development of an eating disorder is almost universally understood to be a desire for increased thinness, almost all females with an eating disorder would agree with this statement, which the EDI would interpret as suggesting an increased likelihood of the presence of an eating disorder. However, one segment of the male population that is known to be at an increased risk for developing disordered eating habits are athletes whose sports require extreme weight changes or unique body compositions. These men are often driven not by a desire for thinness, but a desire for increased muscularity. Therefore, one of these athletes (for example a rugby prop whose position requires extreme lower body strength) who meets all the other criteria of having an eating disorder might realistically disagree with this statement, viewing his thighs as too small. The EDI would interpret his disagreement as suggesting a decreased likelihood of possessing an eating disorder. Even though other questions would presumably offset this so that the assessment would still suggest the presence of an eating disorder, in this instance the individual item not only fails to measure a specifically masculine indicator of an eating disorder, but actually measures it in the opposite direction.

Rather than going through every existing eating disorder assessment, identifying items that have the potential to exhibit gender bias, and then developing criteria for how these assessments are to be modified when being administered to a male, it seems like a more practical solution would be to develop gender-specific assessments to be used when evaluating males. Cohn et al. (2016) identify one such assessment, which was fairly recently developed, titled the Eating Disorder Assessment for Men (EDAM). The EDAM is meant to serve a similar function as either the EDE or the EDI, providing clinicians with an assessment to measure whether or not a client demonstrates sufficient pathologies to indicate the presence of an eating disorder. However, given that the EDAM is a gender specific assessment, unlike the EDE or the EDI, it is not only able to eliminate questions that could potentially be biased towards females, but to replace them with questions that are definitely more applicable to males. Analyzing its development, Stanford and Lemberg (2012) describe how in the sub-scale related to body dissatisfaction, the previously critiqued statement, "I think my thighs are too large" is replaced by the general statement "I am satisfied with my lower body." Although questions such as these admittedly cause the EDAM to sacrifice a degree of specificity, it offsets any vagueness that could potentially develop by incorporating questions specifically designed to identify the multiple different sets of pathologies that are demonstrated depending on the

individual circumstance in which a male develops an eating disorder. For example, Stanford and Lemberg (2012) also identify the inclusion of certain statements such as "I am satisfied with the amount of muscle I have." Disagreement with both of these statements would allow a clinician examining the previously given example of a rugby prop not only to identify his overall dissatisfaction with his body, but also identify a desire for increased muscularity as a potential motivating factor for the development of an eating disorder. Further research is needed regarding clinician familiarity with assessments such as the EDAM, as it remains unclear how frequently this assessment is administered as compared to a more traditional assessment such as the EDE or the EDI when assessing a male client. In addition, increased measures must be taken towards gathering clinician's critique of the preliminary forms of these assessments and either modify existing gender specific assessments when possible or create new ones when required.

However, the creation and modification of more relevant assessment tools is undermined without first taking action to counter the stigma that surrounds eating disorders within the male population. Recognizing this, multiple potential solutions have been proposed. The previously cited study which established the frequency of eating disorders being viewed as the victims fault also suggested that the total score of individuals who knew someone with an eating disorder were almost four times more likely to reflect a positive stance towards eating disorders than a negative one (Crisp, 2005). In addition, a recent meta-analysis evaluating the most effective method of countering general mental health stigma indicated that contact with someone who suffered from a mental health illness was the most effective method of reducing stigma (Corrigan et al., 2012). In light of both these studies, it seems like the natural solution that increased programming and classroom visits organized by mental health advocacy groups—in which those who have suffered from mental illness share their experiences—could serve as the most effective method towards reducing societal stigma.

However, consideration of various logistical elements of this approach and a further examination of the research suggests that this might not in fact be the case. First of all, it would be not only an ambitious, but perhaps an unrealistic goal to facilitate personal contact between those challenged with this issue and the myriad individuals who are unaware that someone they know suffers from an eating disorder. More specifically, given males have historically been both underdiagnosed and undertreated, the number who have recovered or reached a point where they would feel comfortable sharing their experiences with complete strangers through organizations such as the National Alliance on Mental Illness (NAMI) also presents a major logistical barrier. Many who still believe in the contact approach would immediately propose the possibility of video testimony, which would only require a single individual to share their experience and could be more easily distributed to various schools and organizations. However, the same meta-analysis that many have cited in support of contact initiatives also observed a statistically significant decrease in the effectiveness when contact occurred through video rather than in person (Corrigan et al., 2012). In addition, it must be considered what specific segment of the population it would be most effective to target. According to the American Psychological Association's Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) the average age of onset for anorexia nervosa, bulimia nervosa, and binge eating disorder all occur either prior to or at the age of twenty one (APA, 2013). In light of this, it seems most appropriate that efforts to destigmatize eating disorders be targeted toward the adolescent population. A further analysis of this same meta-analysis finds that although contact proved the most effective method of decreasing stigma among the general population, when specifically discussing the adolescent population, increased educational efforts seemed to provide the most effective method of reducing stigma (Corrigan et al., 2012). Although further research must be conducted specifically among the adolescent population to confirm these findings, it is under this understanding the psychological community must currently operate.

If increased educational interventions do in fact provide the most effective method of decreasing stigma, then it comes as no surprise that those with eating disorders still experience a great deal of it. A study conducted examining the high school experience of incoming freshmen at "a large public university in the Southwestern United States" found that only 29% had experienced any sort of eating disorder education. Furthermore, the study indicated no significant difference between those who attended large or small, public or private, and rural, suburban, or urban high schools, suggesting that the lack of curriculum and programing related to eating disorder awareness and prevention is universally lacking (Green & Venta, 2018). Although the study consisted of only 169 participants, which could cause certain populations to be either underestimated or overlooked, it seems very clear that not enough efforts are currently being taken within the schools to promote the knowledge of eating disorders. However, there have recently emerged signs of optimism regarding the potential

for increased mental health awareness in schools. Recently, the NAMI chapter of Virginia reported that alongside New York, they were becoming the first of two states in the nation to require mental health education in the public school system (NAMI Virginia, 2018). Although it is unfortunate that it has taken this long, the courage of the Virginia and New York state legislatures and health educators is to be commended. Although these programs have not been implemented long enough for results to be published, given that the studies analyzed in Corrigan et al. (2012) indicate that increased education reduces mental health stigma among the adolescent population, organizations and individuals advocating for increased mental health programming in schools should soon have data to prove the effectiveness of these educational initiatives to present to their state legislatures and school boards.

However, much of the research related to increased educational efforts has yet to be applied specifically to the male population, which raises the question of how increased educational efforts can benefit this segment of the population in particular. Therefore it might come as a surprise, given the numerous problems surrounding the recognition, diagnosis, and treatment of eating disorders within males, that the most effective first step to be taken by educators could potentially be as simple as presenting eating disorders as what they really are: illnesses that affect males as well as females. Although seemingly a relatively minor step, perhaps an image of a Calvin Klein model next to the Victoria's Secret model or a vignette describing a male alongside the one describing a female could allow some men to feel, perhaps for the first time, that their unique struggles and experiences are just as valid. Additionally, despite fairly recent progress towards increased institutional awareness of mental health disorders, multiple studies have been conducted related specifically to eating disorders that examine the educational approach that both simultaneously increases student knowledge and also reduces stigma. Results of these studies have shown that when providing an etiological explanation for the causes of eating disorders, and by providing information related to the genetic and biological aspects of eating disorders, educators can significantly reduce the belief that eating disorders were self-inflicted (Bannatyne & Abel, 2015; Crisafulli et al., 2008). Given that much of the societal stigma surrounding eating disorders, particularly those experienced by males, seems to revolve around the misconception that eating disorders are the fault of the victim, by explaining the biogenetic factors that contribute to such disorders, educators have the potential to take significant steps towards eliminating blame-based stigma. Although it would be misleading to suggest that underlying genetic factors are the sole reason for the development of eating disorders, given that societal and environmental pressures play a significant role as well, it is the genetic factor of eating disorders that is often either misunderstood or overlooked completely. It is worth noting that these studies would need to be replicated using specifically male case presentations prior to stating that increased educational efforts, gender inclusive teaching methods, and etiological explanations provide the best method of reducing stigma for males with eating disorders. Nevertheless, preliminary results suggest reason for optimism, and considering the prevalence and severity of eating disorders among the male population is better understood now than ever before, there exists no justification for failing to take immediate action.

This paper has examined the unique struggles experienced by men with eating disorders, which numerous qualitative interview studies have indicated revolves around three common themes. The first of these is the experience of an increased stigma for males suffering from eating disorders when compared to other mental health disorders. The second struggle is a general lack of understanding of the prevalence and pathologies of eating disorders among both the general public and the male population specifically. Finally, there seems to exist an implicit gender bias within the eating disorder treatment process, particularly among the assessment methods used to determine the presence of eating disorders. Preliminary results have suggested that in addition to serving as the logical solution to countering the ignorance that exists surrounding eating disorders within the male population, certain educational approaches could also offer the most effective methods of reducing blame-based stigma. In addition, given that many of the current assessments were developed during a period in which cases of eating disorders among the male population were relatively unknown, they frequently contain items and questions that demonstrate implicit gender bias. Therefore, there exists a need for the further development and popularization of male specific assessment tools.

Based on the research of Hudson et al. (2007), it is now known that when examining the population struggling with eating disorders, between a quarter and a third of those suffering are males. Therefore, it has emerged as indefensible for the psychological community not to take immediate action in order to understand the most effective methods to assist this historically underdiagnosed, undertreated, and underrepresented segment of the population. The meta-analysis conducted by Corrigan et al. (2012)

observed that intentional educational efforts seem to not only present the most practical method of increasing knowledge related to eating disorders, but also for reducing stigma among the adolescent population. However, further research must be conducted examining the adolescent population in particular, given that many of the studies in which these patterns was initially observed were not specifically studying this age cohort, but rather the population as a whole. In addition, further research utilizing male vignettes, testimonies, and examples is required prior to definitively stating that gender inclusive teaching strategies and biogenetic etiological explanations are the best methods towards reducing the stigma surrounding eating disorders specifically within the male population. Until the past couple of decades, males have been treated as little more than an afterthought when discussing the prevalence and treatment of eating disorders. It is long overdue that the psychological community recognize the prevalence of eating disorders within men, seek to understand the unique elements of their experiences, and finally advocate for this long underrepresented group.

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