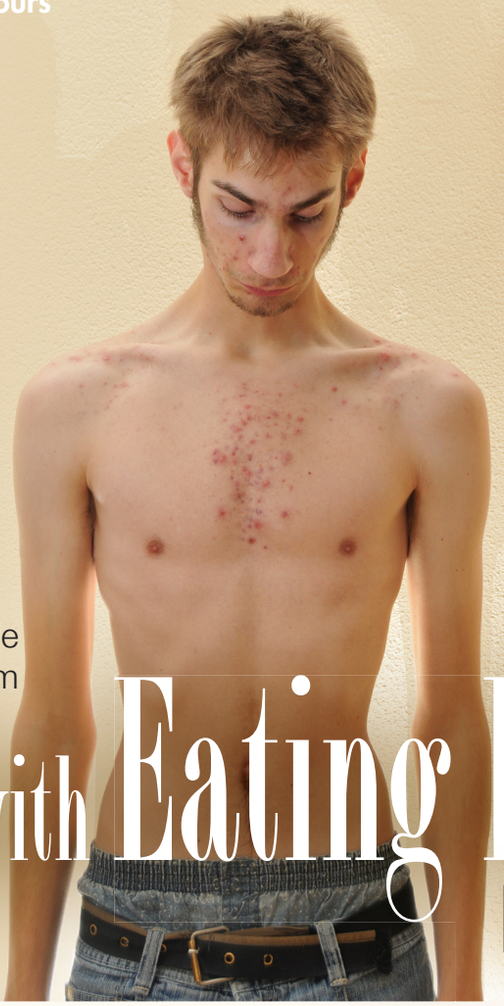
CE Part 2
2.0 contact hours



By Samuel S. Lample
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Guys with Eating Disorders: How to Help

Abstract: *It is possible that 1 to 3 million males in the United States have anorexia and bulimia; thousands more have other forms of disordered eating. Physical complaints often are the first admission of a problem, but symptoms can be misinterpreted resulting in misdiagnosis and ineffective treatment. This article discusses clinical sequelae of eating disorders, specific symptoms and issues in males, and important components of effective treatment.*

Key Words: *eating disorder males, eating disorder treatment, ReddStone*

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THE PROBLEM

As many consider eating disorders to be a female issue, males with eating disorders and their loved ones are less likely to recognize a problem and acknowledge the need for help. Ten years ago, this assertion would have had little relevance, but times have changed. According to various eating disorder authorities, there are likely 1 million (Andersen, Cohen, & Holbrook, 2000; National Institutes of Mental Health [NIMH], 2008) to upward of 3 million U.S. males currently living with anorexia nervosa or bulimia nervosa. These numbers do not include binge eating disorder or other subclinical disordered eating. The implication is hundreds of thousands of eating disorder males need multidisciplinary treatment.

However, counseling and/or psychotherapy modes of eating disorder treatment are incongruent with the male psyche. The male stereotypes of individuality, self-reliance, and emotional repression all decrease the likelihood that males, particularly adults, will seek help (Greenberg & Schoen, 2008). Boys and teens are more likely to find themselves in treatment due to family intervention. Regardless of age, a physical complaint, not the admission of emotional distress, often prompts the first trip to the nurse practitioner or physician (Addis & Mahalik, 2003). Unless healthcare professionals embrace

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the notion that males not only can but also do have eating disorders, symptoms can be misinterpreted resulting in misdiagnosis and ineffective treatment. At this crucial juncture, nurses and primary care providers play an important role, as early intervention is a critical factor in positive outcomes.

Nurses, nurse practitioners, and physicians typically are the front line when dealing with physical suffering, a role that Jesus and his disciples often filled. Jesus' earthly ministry included many accounts of healing those with physical infirmities. James 5:14 reads, "Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord" (NIV). In the New Testament, oil was used for medicinal purposes in addition to its symbolic representation of God's presence or the Holy Spirit. This verse illustrates the combination of common medical practice and spiritual discipline to bring healing, a concept used in modern healing professions. An individual's physical and spiritual needs complement each other; both require simultaneous treatment.

PHYSICAL SYMPTOMS

In the acute phase of the illness, eating disorder symptoms are generally consistent across gender. Anorexia nervosa is associated with extreme weight loss or low body weight for age; a guideline is less than 85% of ideal body weight (American Psychiatric Association, 2000). In children, a failure to achieve expected weight gain thresholds, not necessarily just weight loss, can suggest anorexia. With long-term anorexia, brain shrinkage and permanent cognitive deficits can occur. Bulimia nervosa is associated with eating large amounts of food and immediately engaging in purging behavior designed to expel the calories consumed. Electrolyte imbalances are typical with purging behaviors but also can be a result of starvation; lab values can vary with severity of the eating disorder. Eating disorders impact digestive function as enzyme production becomes deficient. Impaired digestion results in abdominal bloating, pain, elevated liver enzymes, and liver impairment due to inadequate levels of protein.

Prolonged starvation, extended periods of malnutrition, or inconsistent nutrition can cause bone loss and possibly lead to osteopenia or osteoporosis. Some research suggests that bone density loss can be worse in bulimic males than in females (Andersen, 2001). Table 1 lists clinical sequelae of various eating disorders in both sexes.

EATING DISORDER MALES

The presentation of arrested development in males can be useful in identifying an eating disorder. Poor nutrition can result in low testosterone levels or hypogonadism that sometimes requires testosterone replacement. Evidence of pubertal delay in boys can include short stature for age, a noticeable cessation of established growth patterns, or failure to progress toward genetic potential; unusually high voice; lack of facial hair; and limited genital development (M. Schulke, MD, personal conversation, April 14, 2009).

Aside from these obvious gender-specific symptoms, eating disorder males will exhibit the same physical symptoms as eating disorder females. However, physical symptoms can be overlooked in less severe cases. It is therefore necessary to complement knowledge of physical with psychological, relational, and spiritual indicators. ReddStone, a Remuda Ranch Program for Eating Disorders, used this biopsychosocial-spiritual approach to understand and treat eating disorders in young males.

There are four primary reasons why boys go on diets that may ultimately lead to eating disorder onset: teasing for being overweight; attempts to improve athletic performance; efforts to avoid health concerns experienced by other male family members; and attempts to improve homosexual relationships (Andersen et al., 2000). At the ReddStone program, 58% of patients had been teased for being overweight as a child, 38% wanted to lose weight to improve athletic performance or to be chosen to play sports, 33% wanted to avoid serious medical or psychiatric problems such as cardiac disease, diabetes, or bipolar disorder, and 10% experienced some connection between their weight and their sexuality. Asking questions to elicit this type of information during the course of examination will bring clarity to the blurry picture of the male eating disorder.

PSYCHOSOCIAL FEATURES

Psychologically, there are common features shared by eating disorder males. A large percentage of ReddStone patients experienced depression, which frequently includes anhedonia (losing interest in previously enjoyable activities) and irritability. Low self-esteem was typical, evidenced by poor eye contact, passivity, and slumped body posture. It also is possible, although less likely, that the boy will come across as grandiose, almost proving his masculinity through risk-taking behaviors and aggression. Anxiety frequently is present. Difficulty with change, a controlling personality, and an obsessive thought style are typical, even noticeable from childhood.

Whether depression or anxiety, boys with eating disorders are likely to exhibit emotional extremes. They may appear emotionally frozen, or dysregulated, or vacillate between the two. Ultimately, the inability to manage his emotions is what leads to the disorder. Uncomfortable emotion is projected onto the boy's body, which creates body dissatisfaction and distortion that fuels the illness. Body change becomes emphasized, which manifests itself in increased body talk about self and others, comparing one's body to others, and body checking (frequently looking at one's reflection or pinching the body to measure change). Seventy-five percent of ReddStone patients focus on thinness similar to females, but eating disorder males (approximately 29% at ReddStone) can simultaneously focus on muscle gain (Toro, Castro, Gila, & Pombo, 2005). On occasion, muscle focus results in steroid abuse. The abuse of substances in general is commonplace with eating disorder males, particularly those who binge (Weight-Control Information Network [WIN], 2008). Substances are another means to deal with emotion, plus cocaine, crack, and methamphetamines promote weight loss. The search

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Table 1: Potential Clinical Sequelae of Eating Disorders

Dizziness—**A**	Arrested development—**A, B**	Narrowing of left ventricular wall—**A**
Lethargy—**A, B, BED**	Heartburn—**B**	↓ Cardiac diameter—**A**
Thinning hair—**A**	Gastric reflux—**B**	Prolonged QT interval—**A, B**
Lanugo—**A**	Enlarged parotid glands—**B**	Electrolyte imbalance—**A, B** (↓ Potassium, Magnesium, Phosphorous)
Hypothermia—**A**	Dental sensitivity—**B**	
Hypotension—**A**	Angular cheilosis[a]—**B**	Electrolyte-related seizure disorder
Muscle weakness—**A**	Tachycardia—**A, B, BED**	↓ Albumin—**A, B**
Constipation—**A**	Bradycardia—**A**	↓ Blood sugar—**A, B**
↓ Testosterone—**A, B**	Cognitive impairment—**A, B**	↑ Liver enzymes—**A, B**
Hypogonadism—**A, B**	↑ Cholesterol—**BED**	↓ WBCs—**A, B**

A = anorexia nervosa; **B** = bulimia nervosa; **BED** = binge eating disorder

[a]Cracking at the corners of the mouth.

for acceptance through appearance (thinness or lean muscularity) is a social or relational dynamic that reinforces the illness.

Boys with eating disorders often have deficits with social functioning. They struggle with listening, communicating thoughts and empathy, and have difficulty trusting anyone, resulting in isolation and control issues. Young men with eating disorders consistently lack identity, which can end in overly identifying with negative influences. These identity and trust disturbances are theoretically linked to disruptions in the nuclear family associated with poor role modeling. At the ReddStone program, 50% of patients' parents have never been married or are divorced or in the process of getting a divorce. Likewise, 42% of residents have at least one parent who has or has had a substance abuse problem. Both dynamics seem to create a situation in which boys grow up without a consistent, healthy male influence, which adds to identity confusion and fails to provide a model for effective relationship skills.

The Apostle Paul charges fathers to teach their children the ways of the Lord (Ephesians 6:4). Children need help with spiritual formation as they lack the knowledge to mature on their own. The same can be said about emotional maturity. Boys do not inherently know how to be a man; a healthy male role model is imperative for mature identity development. When the male mentor is absent, the boy can become lost. The ensuing intrapersonal emptiness leaves the young man searching for identity and acceptance, making them even more susceptible to social pressures like having the "ideal" male body. The greater the perceived pressure to conform, the more the boy is willing to ignore his values, often creating spiritual distress.

Whether from self, parents, coaches, peers, or religious individuals, eating disorder boys frequently report experiencing judgment and condemnation. They may believe that God must not love them because "bad" things have happened to them or because of what they have done. These beliefs lead to debilitating shame, guilt, and self-hatred, which perpetuate the need for the eating disorder behaviors to cope with such emotion. Spiritual intervention ultimately focuses on developing character and right thinking (Philippians 4:8), thereby giving the young man healthy control over his emotions and his life as a whole. ReddStone and all Remuda programs weave spiritual principles into all treatment components.

THE REMUDA MODEL

The Remuda Model comprises four stages: help, hope, healing, and life. Each patient will pass through the first three stages while in the intensive setting. The life stage refers to any treatment that takes place after the minimum 60-day inpatient treatment experience. ReddStone utilized Cognitive Behavioral and Dialectical Behavioral principles, motivational interviewing techniques, and 12-step based ideas—all solidly undergirded by the belief that God's grace can bring healing to hurting lives. As the ReddStone patients were boys, ages 8 to 17, therapy often was activity based, including art and equine therapy, challenge course, team building activities, and strength training. When clinically appropriate, we use biblical principles to address ineffective thought styles that maintain the illness and perpetuate emotional distress. The weekly Recovery Group utilizes scenes from movies to illustrate teaching points and allow for processing around concepts such as perseverance, identity, personal dignity, forgiveness, hope, and others to cultivate spiritual depth and character growth. Remuda employs a multidisciplinary team approach including primary healthcare providers, psychiatric providers, registered dietitians, licensed therapists and psychologists, education coordinators, and nurses. The nursing department is pivotal in the daily treatment process, providing 24-hour care.

Boys and men have eating disorders. This statement has never been more true and relevant than it is right now in the United States. Whether it is prevention through education, early detection, or inpatient treatment, nurses can offer help, revive hope, assist in healing, and breathe new life into boys with eating disorders and their families.

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