

Bulimia Nervosa in Males: A Case Report

Cicek Hocaoglu¹

*¹Prof. Dr., Recep Tayyip Erdogan University, Faculty of
Medicine, Department of Psychiatry, Rize - Turkey*

ABSTRACT

Bulimia nervosa in males: a case report

Bulimia nervosa (BN) is a severe, life-threatening eating disorder characterized by recurrent episodes of binge eating followed by self-induced vomiting or other purging methods (e.g., laxatives, diuretics, excessive exercise) to prevent weight gain. BN is rare in men compared to women. Etiology, treatment and information on the clinical appearance are limited in males patients with BN. A 23-year-old man with BN is discussed under the influence of his psychiatric illness and his childhood history in the light of the literature examining. In this study, general characteristics and treatment of BN in males are presented, emphasizing different features between genders.

Key words: Bulimia nervosa, eating disorders, male

ÖZET

Erkeklerde bulimiya nervoza: Bir olgu sunumu

Bulimiya nervoza (BN), tekrarlayıcı tıknircasına yemek yeme nöbetlerini takiben kendi kendini kusturma ya da kilo almayı önleyici diğer yöntemlerin (örn: Laksatifler, diüretikler, aşırı egzersiz yapma vb) kullanımı ile karakterize, ciddi, yaşamı tehdit eden bir bozukluktur. BN erkeklerde kadınlara göre nadir görülmektedir. BN'li erkek hastalarda hastalığın etiyojisi, tedavisi ve klinik görünümü ile ilgili bilgiler sınırlıdır. 23 yaşında erkek BN olgusu hastalık öyküsü ve özgeçmiş bilgileri çerçevesinde ele alınmakta, literatür bilgileri ışığında tartışılmaktadır. Bu çalışmada, erkeklerde BN'nin cinsiyet farklılıklarına dikkate alınarak erkeklerde genel özellikleri ve tedavisi sunulmuştur.

Anahtar kelimeler: Bulimiya nervoza, yeme bozuklukları, erkek



Address reprint requests to / Yazışma adresi:
Prof. Dr. Cicek Hocaoglu
Recep Tayyip Erdogan University, Faculty of
Medicine, Department of Psychiatry,
53200 Rize, Turkey

Phone / Telefon: +90-464-217-4274

E-mail address / Elektronik posta adresi:
cicekh@gmail.com

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INTRODUCTION

Eating disorders are psychiatric conditions presenting with the disturbance of eating behaviors in different ways, including biological, psychological and familial factors (1). It is estimated that the frequency of eating disorders is 0.2-1%. It is reported that in women eating disorders are diagnosed five times more often than in men; 4% of all patients are men (1-3). The increase in the frequency of eating disorders raises growing concern (1-5). The fact that men can suffer from eating disorders was first talked about in the early twentieth century (2). There are studies indicating that the frequency of this disease increases among men, too. These studies suggest that the disease is underdiagnosed in men due to embarrassment and an effort at hiding the condition (6-8). It is thought that the fear of obesity is epidemic and the perception of the ideal body is changing in all societies due to an increase in mass communication presenting an ideal body image. Consequently, the frequency of eating disorders increases (6,9,10). Patients

with eating disorders often simultaneously display other psychiatric disorders. In a study on this issue, it was reported that an additional psychiatric disorder was found in 53% of the patients (11). There are also studies showing that there is a relation between eating disorders and major depression (12,13). This information is supported by family studies, and it is based on the relationship between the two disorders and serotonergic systems (2,12,13). It is thought that the self perception of these patients is lower than normal, a state that may play a role in causing depression. Anxiety disorders, suicidality, alcohol and substance abuse, and personality disorders have been reported to accompany eating disorders (12,13). There are studies reporting that the incidence of homosexual and asexual behavior among male cases is higher than statistically expected in society (14-15). Binge eating and then trying to vomit by force so as not to gain weight are characteristic of bulimia nervosa (BN). To make the diagnosis of the disease, both binge eating and inappropriate balancing behavior must occur at least twice a week for three months (4).

Patients are ashamed of their eating disorder and tend to hide it. The binge eating is done secretly; a feeling of discomfort is present and the sensation of losing control. BN is seen at a rate of 1-3%. It is more frequent in women (4). The frequency, clinical presentation and the etiology of BN in males are not conclusively known. In the following case, a male BN patient who makes himself vomit with a TV cable following his eating binges is analyzed in the framework of dynamic theories with regard to his clinical history and his personal information.

CASE

A.S. is a 23-year-old male, single university student, born in Trabzon, living with his family. He had been taken to the psychiatric service by his girlfriend upon persuasion by his family because of changes in his eating habits during the last year. He stated that he was aware of his problem and also knew how to solve it by himself. His girlfriend said that they had known each other for 3 years; in the beginning, their relationship had been more harmonious, but for the last year, AS had been more nervous and tense, alienated himself from his friends, and experienced frequent problems in his bilateral relations; he had been missing classes from time to time, being fussy about his meals, frequently obsessed about his body, and avoided eating out for the last year. Also, she stated, he ate excessively and then made himself vomit, and as she had witnessed three times, he used a TV cable, which scared her very much. His mother and older sister, who had been brought in for a consultation, said that AS had been on a diet for 3 years as he thought that he was overweight; he had not eaten home-cooked meals, because he found them too fatty, had changed his eating habits and vomited after meals, complaining about feeling bloated; he used thyroid medication to lose weight, and frequently engaged in sports activities. In the one-to-one conversation, AS said that he avoided gaining weight, but he could not control his eating binges, which lasted about two hours and occurred two or three times per week, and that he vomited immediately afterwards. He added that he could not control his eating habits, lost

himself while eating and swallowed without chewing whatever he found to eat, especially soft food such as biscuits, cakes, or ice-cream; right afterwards he made himself vomit out of fear to gain weight and was embarrassed.

Growing up and Social History: The patient was born normally, as a result of a planned pregnancy, the fourth and last child of his family. He did not have any history of difficult birth or of disease during his infancy. He had learned to walk and speak in the right time. He was fed with breast milk for one year and the weaning process did not lead to any difficulties. His mother is 53 years old, university graduate, a retired teacher, and still manages a children's nursery. His father is 57 years old, university graduate, working as an engineer. The parents met 32 years ago and had got married following a one-year engagement period. There is no blood relationship between them. It turned out that in the first years of their marriage, his mother had problems with her mother-in-law, and for this reason she had often argued with her husband. His mother had fainted especially in troublesome situations during this period and had been in psychiatric treatment for some time. AS defined his mother as oppressive, resentful, rigorous, perfectionist and authoritarian, whereas he described his father as reticent, introverted, and hardworking. He remarked that his mother called the shots in their home. It was also established that AS had often had problems with his mother since his childhood. AS has two older sisters aged 31 and 29. The older sister, who was divorced from her husband 2 years ago, and the other sister, who is single, live with the family. AS stated that he got on well with the older sister but frequently argued with the other sister, because the latter resembled his mother. AS's older brother drowned when he was 3. After that, his mother locked herself in the house and did not see anybody, lost weight, and for a while received psychiatric treatment. AS said that they did not talk about the older brother at all at home and also added that even talking and asking about him were forbidden. AS completed his primary, secondary and high school education in Trabzon. He explained that he had been an overweight child during primary and secondary school and had been called names by his friends for this reason.

He was a successful student, but he could not pass the university entrance exam for three years. He is still a student at a department which he entered two years ago. His attendance and school success have not been good. Previously, AS has not encountered any serious health problems. There are histories of psychiatric treatment in his family, especially with his mother and his second oldest sister. AS defined himself as timid, shy, distrustful and having had few friends before the diseases. It was learnt that AS had not had any girlfriends until university and had not had any sexual experience. He also reported that he had smoked for some time during high school and that his mother hit him when she found out; he did not have any other addictions apart from this. It was established that his eating and sleeping habits had changed since he got ill.

According to his physical examination, he is 1.73m tall and weighs 53kg and his body mass index is 17.7kg/m². Also, laboratory findings and brain electroencephalography were found to be normal.

Mental State Examination: His clothing was in accordance with his socio-cultural situation. His self-care was good. He appeared weak, was willing to communicate and respectful. He made eye contact, but his cooperation was limited. Speed and quantity of his speech were normal. His affective state was angry and his mood was depressed; his memory and intelligence were normal, his attention and concentration were satisfactory. Despite his ability to evaluate reality, he could not perceive his body as normal. He did not describe any hallucinations or delusions. His mind was overly concerned with eating and vomiting. Self-esteem was reduced. The Hamilton Depression Scale was determined at 18 points and the Eating Attitude Test result was determined at 49 points (cut-off score 26). According to the Minnesota Multiphasic Personality Inventory, he was evaluated as perfectionist, insecure, fragile, and extremely sensitive about interpersonal relations. As a result of psychiatric evaluation, AS was diagnosed with depression and binge eating/purging type BN according to the American Psychiatric Association (1994) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Therefore, he was started on fluoxetine, 20mg/day. The dose was

gradually increased to the amount of 60mg/day. In differential diagnosis, binge eating/purging type AN was not assumed to be present, given that he was not too weak. Also, there are no findings related to other psychiatric diseases potentially leading to weight loss that would have to be taken into consideration in differential diagnosis, no history of medical disease or substance abuse. The patient's fear of obesity and weight gain and his body image were relieved by a Cognitive Behavioral Treatment (CBT) program. Through family therapy, family members were educated about the disease and its treatment and family relations were revised. The patient, who did not have any significant complaints in the eighth month, is still under treatment, while his school success improved and family relations recovered.

DISCUSSION

Results of epidemiologic studies correlate the observed increase of eating disorders with rapid changes in society and increasing westernization and industrialization, leading to a dissolution of the family structure, and with inadequate social support systems (1,4,16,17). Even though the incidence of EDs is not as high in Turkey as it is in western countries, its increase over the years is conspicuous (2,4,18). It can be said that fast sociocultural changes in this country have facilitated the development of eating disorders. It is important to point out that the case presented in this study took place in a region with a lower socioeconomic level compared to the western provinces of Turkey. Within all eating disorders, the rate of male patients is about 5-15% (19). This rate may be higher in reality, but concerns caused by speculations that eating disorders are a condition specific to women and homosexual men may be the reason for a less common diagnosis in men, given the absence of eye-catching symptoms such as secondary amenorrhea and the possibility that clinicians wrongly believe eating disorders to be peculiar to women, which can also reduce the compliance of male patients (20). In other words, it is thought that eating disorders are peculiar to women, but in fact they can be seen in both sexes. There are numerous studies related especially to

AN in the literature, whereas information related to BN is insufficient. In the limited number of studies on this topic, it has been reported that the average age of onset of BN in men is between 18 and 26 years. In women, the reported onset age is earlier than in men, namely, 15-18 years (8,19,20). The fact that the patient in our study was 23 years old conforms to these findings. However, we should not forget that the claim about BN's manifesting itself in men at a later age compared to women needs to be confirmed through studies with a larger sample. In addition, as in other eating disorders the diagnosis of BN in men is important for the treatment of the disease and when it develops into a chronic condition. The fact that in our patient symptoms had begun three years before the diagnosis is in accordance with this assertion. It has been reported that in male patients with BN, the rate of those having been overweight before the onset of the disease, including triggering factors at the onset of the condition such as criticism by friends or family members or hearing jokes about obesity, is elevated (21,22). The fact that the patient in our case had been overweight during primary and middle school and been called names by his friends corroborates these observations. From a clinical perspective, male BN patients differ from females in that the former pay less attention to weight loss, use diuretics, laxatives, and diet pills, and develop a greater fluctuation of weight during their disease (21). Men are also found to be more active and more interested in sports (23). In our case, it is remarkable that to lose weight, the patient used thyroid drugs and participated in sports he had never been interested in before. In women suffering from BN, a large number of studies has found comorbidity with depression, anxiety disorders, substance abuse, and personality disorders (esp. cluster B: borderline, histrionic, narcissistic, and anti-social) (12,13). A similar profile of psychiatric comorbidity was reported in male BN patients (19,20). Perfectionist personality traits and comorbid depression in our study support this finding. In addition, substance abuse and impulsivity were more frequently observed in male BN patients (21,22). In our study, however, apart from a brief period of smoking, no kind of substance abuse was determined. This might be explained with the relatively

small size and conservative structure of the province where our patient lives. In the great majority of cases, familial relationships are among the reasons of eating disorders (24). When examining a significant number of family histories of patients diagnosed with BN, problematic family relations become apparent. Patients define their parents as 'distant and unapproachable'. Some findings show that patients have close but problematic family relationships. It is thought that binge eating represents integration with the mother, while the subsequent elimination and vomiting behavior presents as an effort of separation from the mother and individualization. It has been suggested that there is a family pathology making it difficult for the child to improve his or her autonomy, thus causing them to remain in a child-like state (25). It has been reported that patients who had been overweight before the onset of BN took up dieting because of family pressure. For instance, in one study the rate of starting a diet after family pressure was 55% (26). As mentioned before, our patient had been overweight as a child and for this reason had experienced difficulties in his family and school life. Compared to a control group, the families of BN patients display more hostility and feelings of isolation, with significant deficits in child rearing (care) and establishing empathy. In our case, when family relations were analyzed, it was seen that the patient presented similar characteristics such as a problematic relationship with his mother and distant relation with his father. Similarly, it has been reported that families of BN patients tend to be unsupportive, chaotic, and prone to secrecy (21). When we looked at the family dynamics, the mother was defined as "overbearing, irritable, pedantic, perfectionist, and authoritarian", who was good when others behaved the way she wanted, otherwise oppressive and irritable. From the received history, it could be said that the mother played the role of the authority figure in the family and her general attitude was to apply strict family norms to all members, not allowing the children to grow up and develop into individuals. The father, on the other hand, is described by the patient as "reticent, introvert, and hardworking". Given that he hardly made himself heard in the family and remained silent when the mother shouted during

discussions or even got up and left the table when an argument erupted during a family meal, the father may not have been able to provide a role model for a male child to develop his early sexual and personal identity. It is also possible that the patient, by refusing to eat the meal while sitting together with the family, witnessing the quarrels between his parents, symbolically protested against his father's silence and the family norms. The rate of psychiatric diseases seen in families of ED patients is high. In our case, the patient's mother and his older sister both had a history of psychiatric treatment. It is remarkable that the mother went through a long period of mourning and serious weight loss after she had lost her three-year-old son before the patient was born. In this period the mother may have neglected her other children emotionally. Thus, the mother reported that after she had lost her first son, her mother looked after her two daughters, while she became pregnant to forget her pain and gave birth to our patient, AS. However, she could not forget her first son and had difficulties to accept AS. The patient, too, stated during the consultations that there was a strong bond between his mother and his older brother, and he thought it possible that his mother wished he had died instead of her first son. The patient added that for his whole life he had been "in competition with his older brother" to receive his mother's attention. As mentioned in the case presentation, though talking about the dead brother or even asking about him were forbidden at home, it may be said that the older brother lost in a tragic event was the greatest obstacle between AS and his mother. Also, the fact that the mother had not been able to accept the patient for a long time after birth and continued to punish him by hitting until high school age reflects a lack of emphatic mirroring and may mean that integrity of identity has not yet developed. Through the changes in his eating behavior, it is possible that the patient, out of fear to be separated from his mother and develop his individuality, attempted through his weight loss to reach a stage where he required his mother's care; in this way, hunger and need for food would be equated with love in an infantile regression as a call for his mother's love and attention and a rejection of physical growth. Alternatively, the patient's rejection of

food and his vomiting behavior could be seen as a rejection of the overprotective and watchful mother, who did not allow for independence and individualization, or an expression of the jealousy and hatred he felt for his dead brother. There is also a striking difference between the way mother and father were taking care of the children and their attitudes in our case. During the therapy, mother and father expressed differences in the interest they showed and felt in describing the deficit in paying sufficient attention to their children. Communication within the family, family structure, and the characteristics of familial relationships and interactions are seen as the most important determinants for the functioning of a family. For this reason, the way to remediate the pathologic behavior is to identify the patterns formed by organizational, structural, communicative, interactional and functional characteristics of the family. It is known in BN patients that eating binges and subsequent vomiting are observed after stressful life events. In our case, too, it was seen that symptoms occurred especially after experiencing problems with his girlfriend or his mother. Like in many BN cases, our patient was hiding his condition for a long time. In treating BN, the importance of CBT alongside family therapy is undisputed, because it does not seem that the treatment of eating disorders can be successful without dealing with the family. CBT targets a wrong attitude to eating and the exaggerated concern with body weight. Similar applications were used in our case. The therapies provided to the patient especially addressed the effort at separation and individuation with its concomitant adversities and the feelings and thoughts regarding his dead brother. We worked to develop a more adaptive and healthy coping strategy to replace his body which he had used as a transitional object in his struggle. Studies have shown that high dose fluoxetine as approved by the U.S. Food and Drug Administration (FDA) can be effective in BN treatment (27). In our study, 60mg/day fluoxetine was used.

BN is an eating disorder mostly affecting women, commonly found in developed western countries. The incidence of the disease is rapidly increasing in developing countries, including Turkey. The

difficulties experienced in BN treatment motivate clinicians to seek a better understanding of the disease. Especially in male patients, the reasons for developing the disease as well as clinical and therapeutic approaches have not been sufficiently studied. It is well known that many different processes

play a role in developing BN, and among those, psychodynamic factors are fairly important. Finally, social and familial interactions have a role in BN. It is obvious that larger case series and comprehensive studies are required to understand BN in male patients better.

REFERENCES

- Ozdel O, Atesci F, Oguzhanoglu NK. An anorexia nervosa case and an approach to this case with pharmacotherapy and psychodrama techniques. *Turk Psikiyatri Derg* 2003; 14:153-159. (Turkish)
- Tahiroglu YA, Firat S, Somer DR. Eating disorders in male children a case of anorexia nervosa. *Turkish Pediatric Journal* 2005; 48:151-157. (Turkish)
- Tomova A, Kumanov PH. Sex differences and similarities of hormonal alterations in patients with anorexia nervosa. *Andrologia* 1999; 31:143-149.
- Maner F. Eating disorders. Reviews, Cases and Hypotheses in *Psychiatry* 2007; 1:21-29. (Turkish)
- Fornari V, Dancyger IF. Psychosexual development and eating disorders. *Adolesc Med* 2003; 14:61-75.
- Hedlund S, Fichter MM, Quadflieg N. Expressed emotion, family environment, and parental bonding in bulimia nervosa: a 6-year investigation. *Eat Weight Disorder* 2003; 8:26-35.
- Woodside DB, Garfinkel PE, Lin E, Goering P, Kaplan AS, Goldbloom DS, Kennedy SH. Comparisons of men with full or partial eating disorders, men without eating disorders, and women with eating disorders in the community. *Am J Psychiatr* 2001; 158:570-574.
- Daniel J, Carlat MS. Review of bulimia nervosa in males. *Am J Psychiatr* 1991; 148:831-843.
- Henriques GR, Calhoun LG. Gender and ethnic differences in the relationship between body esteem and self-esteem. *J Psychol* 1999; 133:357-368.
- Hepp U, Milos G. Gender identity disorder and eating disorders. *Int J Eat Disorder* 2002; 32:473-478.
- Herpetz-Dahlman B. Outcome in adolescent anorexia nervosa. *Acta Neuropsychiatrica* 2002; 14:90-98.
- Wade TD, Bulik CM, Neale M, Kendler KS. Anorexia nervosa and major depression: shared genetic and environmental risk factors. *Am J Psychiatr* 2000; 157:469-471.
- Muller B, Herpertz S, Heussen N. Personality disorders and psychiatric morbidity in adolescent anorexia nervosa. Results of a prospective 10 year catamnesis. *Z Kinder Jugendpsychiatr Psychother* 2000; 23:34-38.
- Katsumi T, Osamu N, Takashi S. Contingent negative variation in children with anorexia nervosa. *Pediatr Int* 1999; 41:285-292.
- Wunderlich U, Fichter M. Bulimia nervosa in homosexuality and HIV infection in the man. Case report. *Nervenarzt* 2001; 72:558-561.
- Goodman A, Heshmati A, Malki N, Koupil I. Associations between birth characteristics and eating disorders across the life course: findings from 2 million males and females born in Sweden, 1975-1998. *Am J Epidemiol* 2014; 179:852-863.
- Qian J, Hu Q, Wan Y, Li T, Wu M, Ren Z, Yu D. Prevalence of eating disorders in the general population: a systematic review. *Shanghai Arch Psychiatry* 2013; 25:212-223.
- Vardar E, Erzen M. The prevalence of eating disorders (EDs) and comorbid psychiatric disorders in adolescents: A two-stage community based study. *Turk Psikiyatri Derg* 2011; 22:205-209. (Turkish)
- Staten RA. Eating disorder in a young active duty male. *Mil Med* 2013; 178:884-889.
- Chen CK, Tao ZL. Binge eating disorder in a Chinese male--a case report. *Eur Eat Disord Rev* 2010; 18:154-157.
- Szabó P, Túry F. Prevalence of clinical and subclinical forms of anorexia and bulimia nervosa among working females and males. *Orv Hetil* 1995; 136:1829-1835.
- Carlat DJ, Camargo CA, Herzog DB. Eating disorders in males: A report on 135 patients. *Am J Psychiatry* 1997; 154:1127-1132.
- Steiger H. Anorexia nervosa and bulimia in males: Lessons from a low-risk population. *Can J Psychiatry* 1989; 34:419-424.
- Sayin A, Kuruoglu AC. A Male Anorexia Nervosa Case and its Discussion from Dynamic Point of View. *Turk Psikiyatri Derg* 2004; 15:155-160. (Turkish)

25. Toker ED, Hocaoglu C. Eating disorders and family structure. *Düşünen Adam The Journal of Psychiatry and Neurological Sciences* 2009; 22:36-42. (Turkish)
26. Maner F, Aydin A. The psychosociocultural factors in bulimia nervosa. *Düşünen Adam The Journal of Psychiatry and Neurological Sciences* 2007; 20:25-37. (Turkish)
27. Hay PJ, Claudino AM. Clinical psychopharmacology of eating disorders: a research update. *Int J Neuropsychopharmacol* 2012; 15:209-222.