to create a federal Office of Men's Health to promote research and education about diseases affecting men. Since the late 1990s the Office of Population Affairs/Office of Family Planning has funded programmes that address family planning and reproductive health information and services for men and boys (www.hhs.gov/opa/titlex/ofp.html).

In Australia, a country that has probably done more than any other to develop men's health as a mainstream issue, the federal government supported a national men's health conference in Melbourne in 1995, and a range of government funded initiatives has followed. These include a draft national policy, a second national conference, a parliamentary investigation, and policy initiatives in several states.[4]

Finally, the development of international discussion and collaboration on men's health will enable these new societies and forums to take the next step of putting men's health on the agenda of mainstream international bodies such as the European Commission and the World Health Organization. This will, in turn, strengthen the case within individual countries for establishing men's health initiatives.

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Body dysmorphic disorder in men

Psychiatric treatments are usually effective

Body image isn't just a women's problem. Many studies reveal that a surprisingly high proportion of men are dissatisfied with, preoccupied with, and even impaired by concerns about their appearance.[1] One American study, for example, found that the percentage of men dissatisfied with their overall appearance (43%) has nearly tripled in the past 25 years and that nearly as many men as women are unhappy with how they look.[1]

A more severe form of body image disturbance—body dysmorphic disorder or dysmorphophobia—is an underrecognised yet relatively common and severe psychiatric disorder.[2] Body dysmorphic disorder affects as many men as women[3 4] and consists of a preoccupation with an imagined or slight defect in appearance that causes clinically significant distress or impairment in functioning. Patients with body dysmorphic disorder often present to non-psychiatric physicians, with reported rates of 12% in dermatology settings and 7-15% in cosmetic surgery settings.[5] Although the symptoms of body dysmorphic disorder might sound trivial, high proportions of patients require admission to hospital, become housebound, and attempt suicide.[3] In a study of dermatology patients who committed suicide most had acne or body dysmorphic disorder.[6]

Men with body dysmorphic disorder are most commonly preoccupied with their skin (for example, with acne or scarring), hair (thinning), nose (size or shape), or genitals.[3 4] The preoccupations are difficult to resist or control and can consume many hours each day.[3] Nearly all men with body dysmorphic disorder perform repetitive and time-consuming behaviours in an attempt to examine, fix, or hide the "defect." The most common are mirror checking, comparing themselves with others, camouflaging (for example, with a hat), reassurance seeking, and excessive grooming.[3]

A recently recognised form of body dysmorphic disorder that occurs almost exclusively in men is muscle dysmorphia, a preoccupation that one's body is too small, "puny," and inadequately muscular.[1] In reality, many of these men are unusually muscular and large. Compulsive working out at the gym is common, as is painstaking attention to diet and dietary supplements. Of particular concern, muscle dysmorphia may lead to potentially dangerous abuse of anabolic steroids, and studies indicate that 6-7% of high school boys have used these drugs.[1] While the cause of body dysmorphic disorder is unknown and probably multifactorial, involving genetic-neurobiological, evolutionary, and psychological factors, recent social pressures for boys and men to be large and muscular almost certainly contribute to the development of muscle dysmorphia.

Body dysmorphic disorder interferes with functioning[2 4–7] and may lead to social isolation, difficulty with job performance, and unemployment. In a study that used the SF-36 to measure health related quality of life, outpatients with body dysmorphic disorder scored notably worse in all mental health domains than the general US population and patients with depression, diabetes, or a recent myocardial infarction.[7]

Patients with body dysmorphic disorder can be challenging to treat.[8] However, recent research findings are encouraging, with clinical series, open label studies, and controlled trials indicating that serotonin reuptake inhibitors are effective for most patients.[9] Higher doses and longer trials than those usually used for depression are often needed.[9] Clinical series and studies using untreated controls waiting for treatment suggest that cognitive behavioural therapy is also effective.[10] This treatment helps patients develop more realistic views of their appearance, resist repetitive behaviours, and face avoided social situations. Other types of psychotherapy or counselling, in contrast, do not appear effective.[2]

Most men with body dysmorphic disorder, however, receive dermatological, surgical, or other non-psychiatric treatment.[11] Although rigorous studies are lacking, the data suggest that these treatments are usually ineffective.[11] Some patients are so disappointed with the outcome that they become severely depressed, suicidal, litigious, or even violent towards the treating

BMJ 2001;323:1015–6

physician. A recommended approach[5] is to educate patients about the disorder and effective psychiatric treatment. It is probably best to avoid cosmetic procedures. Simply trying to talk patients out of their concern is usually futile.

Although body dysmorphic disorder has been described for over a century and reported around the world, it remains underrecognised and underdiagnosed.[2] Men and boys are often reluctant to reveal their symptoms because of embarrassment and shame, and they typically do not recognise that their beliefs about their appearance are inaccurate and due to a psychiatric disorder. Physicians can diagnose body dysmorphic disorder in men with a few straightforward questions.[5 12] These determine whether the man is concerned about and preoccupied with minimal or non-existent flaws in his appearance and whether this concern causes significant distress (depression, anxiety) or interferes with social, occupational, or other aspects of functioning. The challenge is to enhance both physicians' and the public's awareness of body dysmorphic disorder so that effective treatments can be offered and unnecessary suffering and morbidity avoided.

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Tackling coronary heart disease

A gender sensitive approach is needed

Coronary heart disease is the commonest cause of death in the United Kingdom, with marked gender differences in incidence, presentation, referral, recovery, and rehabilitation.[1–6] Current policy on coronary heart disease is written in gender neutral language at a time when treatment has been moving towards a more behavioural model, where cardiac rehabilitation is a therapeutic option and changing cardiac health behaviour a major objective. Given the importance of this there is a need for health strategy that is gender sensitive.

The government views the national service framework for coronary heart disease as its "blueprint" for tackling heart disease.[7] It lays out 12 standards and sets out services that should be available throughout England. Although the framework acknowledges gender differences, there is no clear recognition in the guidelines of how these are to be addressed.

In part this is due to the evidence on which the guidelines have been based. Relatively small numbers of women, older people (both men and women), and ethnic minorities have been included in biomedical research into coronary heart disease, which has largely ignored women and treated white low risk men presenting with their first acute episode as a convenient sample. This is possibly due to the difficulties associated with controlling for comorbidity in older men and women, and the ethical and legal problems associated with fertile women who may be pregnant.[8] Therefore it has been customary to apply the conclusions of research to populations not studied, since it has been thought reasonable to assume there is no biologically plausible reason to expect findings to vary between the sexes. There is evidence, however, that women have not been well catered for by services underpinned by existing research. Studies that have included women appear to have had deficiencies in recognising and treating coronary heart disease.[5]

These difficulties for women are compounded by the existing consensus among both the public and health professionals that coronary heart disease is a disease of men.[9 10] In a recent study in which women with coronary heart disease were interviewed, one participant talked of men she knew being potential coronary candidates but she did not view herself as at risk as she was a woman and could not think of any famous women who had had a heart attack.[11]

The current research focus therefore has meant that women's experience has not been captured and used in service delivery—but neither, it may be argued, has men's. Despite most research being undertaken on men we are not much closer to an understanding of how men experience coronary heart disease. This is due to the failure of much research to acknowledge the gender sensitive nature of coronary heart disease and thus to treat gender as a variable to be controlled. Gender effectively becomes invisible, resulting in research that does not consider the issue of masculinity and men's acknowledged difficulty in managing their health.[12 13] Despite coronary heart disease being

BMJ 2001;323:1016–7