

Males and Eating Disorders: Gender-Based Therapy for Eating Disorder Recovery

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Mental health professionals may wonder how males with eating disorders differ from females with eating disorders and how best to treat males with eating disorders. The eating disorder literature largely focuses on females. Limited research has examined assessment and treatment of eating disorders in males. This article offers a unique view of eating disorder treatment for males by integrating it with the literature on the psychology of men. Mental health professionals are given practical suggestions to guide eating disorder recovery in males. A case example shows treatment considerations for working with males with disordered eating behaviors.

Keywords: males, gender based, eating disorders, treatment, recovery

Historically, health professionals have associated eating disorders with women. Today, mental health professionals are aware that both women and men suffer from eating disorders. Yet, males with eating disorders have been overlooked, understudied, and underreported. A therapist may wonder, What distinguishes a man with an eating disorder from a woman with an eating disorder, other than individual differences? Others may ask, How may I most effectively treat my male client who struggles with an eating disorder? Masculinity is likely to affect males' experience of disordered eating and their help seeking for eating disorders.

The purpose of this article is to offer mental health professionals practical suggestions to guide assessment and treatment of males with disordered eating. We discuss gender differences in eating disorders and how these differences impact assessment and treatment. We offer a unique framework for eating disorders in males by integrating a psychology-of-men perspective into eating disorder treatment. With a case vignette, we demonstrate individual psychotherapy for eating disorders from a gender-based perspective.

Scope of the Problem

There is long-standing evidence that starvation leads to negative consequences, not only for women but for men as well. Thus,

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physiologically, both men and women can be subject to eating disordered symptoms. For instance, as early as 1946, Keys showed that men, ages 20–33 years, experienced adverse effects, such as weight loss, depression, fatigue, edema, bradycardia, and anemia, during a period of enforced starvation. Men and women who starve themselves experience similar medical complications. However, motives for restricting calories are likely to differ across genders. Women may restrict to avoid appearing fat, whereas men may seek defined muscularity (i.e., six-pack abs). Mental health professionals are likely to see more men with disordered eating as the male standard of bodily attractiveness in Western culture increasingly reveres big, bulky, and muscular men (McCreary & Sasse, 2000).

Prevalence and Incidence Rates

Eating disorders are not limited to women. In one study, nearly 7% of eating disorder cases included adolescent boys ages 14–15 (Kjelsas, Bjornstrom, & Gotestam, 2004). The media has addressed men's struggle with eating disorders. *The Washington Post*, for instance, recently published, "Eating Disorders: Not Just for Women" (Boodman, 2007). Few studies have reported prevalence and incidence rates of eating disorders among males. In particular, data in the 1990s suggested that males comprise less than 1% of anorexic individuals and 0.8% of bulimic individuals. In comparison, average prevalence rates for females are 0.3% for anorexia nervosa and 1.0% for bulimia nervosa (Hoek & van Hoeken, 2003). Hudson, Hiripi, Pope, and Kessler (2007) conducted a U.S. population survey from 2001 to 2003. Lifetime prevalence rates for males with anorexia and bulimia were 0.3% and 0.5%, respectively, compared to 0.9% and 1.5% for females with anorexia and bulimia. Andersen (1999b) noted that men, particularly older men with excess weight, are more likely to experience binge eating disorder than anorexia or bulimia because being overweight and/or overeating are culturally sanctioned. Thus, males with binge eating disorder may be overlooked.

Presentations of Males With Eating Disorders

In general, research has indicated that there are many similarities between eating disorders among males and females. In partic-

ular, both genders show similar rates of psychiatric comorbidity (e.g., Olivardia, Pope, Mangweth, & Hudson, 1995; Woodside et al., 2001). Common comorbid presentations in males with eating disorders are major depression, substance abuse, anxiety disorders, and personality disorders. For instance, Andersen (1999b) noted that anorexic males tend to appear anxious, intropunitive, or obsessive–compulsive and that bulimic males may appear theatrical and narcissistic.

Andersen (1999b) has written extensively on eating disorders in males. He has delineated the few, yet important, ways that males with eating disorders differ from females with eating disorders. These differences can influence assessment and treatment. Females, for instance, may complain about their weight in terms of pounds or clothing size or their body shape from the waist down (e.g., thighs, hips, buttocks), whereas males typically report body dissatisfaction from the waist up, particularly chest and arms. Males tend to strive for less fat and greater muscle definition, given that they are socialized to believe muscular men are more masculine and attractive than less muscular men. A man, therefore, risks suffering reverse anorexia nervosa or muscle dysmorphia, where he is preoccupied with the idea that his body can be leaner or more muscular. Olivardia (2007) noted that eating disorders occur in roughly one third of men with muscle dysmorphia.

Males may diet for various reasons. First, males with eating disorders typically have a history of premorbid obesity and may diet to combat excess weight. Thus, males may be genuinely overweight compared with females who may feel fat despite actually being average weight or thin. Second, men may want to lose weight to avoid weight-related medical complications experienced by their fathers. Third, males may seek to improve their appearance given a history of childhood teasing (Andersen, 1999b). Fourth, males may diet to improve athletic performance (e.g., running, weight lifting, wrestling, and basketball). Fifth, men tend to use different weight loss methods than women, possibly because of higher metabolic rates in males, which help them lose weight without using diet pills and purgatives (Braun, Sunday, Huang, & Halmi, 1999). For instance, Hay, Loukas, and Philpott (2005) found men were less likely to self-induce vomiting to control their weight. This finding supports Andersen's (1999b) data showing males with bulimia nervosa purge following binge eating in 80% of the cases, whereas 20% of males use other compensatory forms such as excessive exercise or starvation. Males who starve themselves often begin with a lower reserve percentage of body fat and higher lean muscle mass compared with starved females.

The Impact of Gender on Diagnosis

Eating disorders are often not recognized in men. Identifying males with eating disorders can be challenging. First, males may give more medically reasonable motives for dieting than women and therefore may not be diagnosed. As stated previously, a man may report efforts to lose weight to avoid getting heart disease and/or diabetes. Second, even though the same diagnostic criteria for eating disorders are applied to men and women, physicians are more likely to recommend treatment when the patient is female (Curran, Schmidt, & Waller, 2007). The diagnostic criteria at this point favor women, particularly with regard to amenorrhea as a core criterion for anorexia. Instead of amenorrhea, abnormal re-

productive hormone functioning (reduced testosterone) may be used for males. Men may show loss of sexual interest and impotence related to disturbed eating, which can help guide diagnostic decisions (Andersen, 1990). Third, diagnosis aside, admitting to an eating disorder can be difficult for both males and females. However, unlike females, males face additional shame and/or stigma for acknowledging that they suffer from a disorder that is perceived to be a women's problem (Carlat, Camargo, & Herzog, 1997).

In short, it is important for mental health professionals to consider how masculinity might impact diagnosis, assessment, and treatment in disordered eating. Empathic mental health professionals can help males with eating disorders feel more understood and less isolated in a society that often stereotypes eating disorders as a female phenomenon.

The Impact of Gender on Treatment Outcomes

Mental health professionals may wonder to what extent gender impacts eating disorder treatment outcomes. Treatment outcomes tend to be similar across genders, such that males, like females, experience poor prognosis if they present with dangerously low or chronically low weight, severe comorbidity, and poor family support (Andersen, 2002). Moreover, Woodside and Kaplan (1994) found that male and female patients responded equally well to eating disorder treatment.

Current outcome studies tend to include few male relative to female participants. For instance, Bean et al. (2004) included 10 male participants out of 33, and Strober, Freeman, and Morrel (1997) included only 10 male participants out of 95. Specifically, Bean et al. examined outcomes for male patients with anorexia nervosa admitted to a residential eating disorder treatment center program from 1998 to 2002. Results showed that male participants experienced, on average, greater weight gain (19 lbs) than female participants (7 lbs) from discharge to follow-up at 15 months. However, another study found that female patients admitted to this same eating disorder treatment facility showed better progress than males in reducing symptoms over time, even though females began treatment with more psychopathology (Bean, Maddocks, Timmel, & Weltzin, 2005).

Few outcome studies have focused exclusively on males, although there are currently no residential programs that offer services exclusively for the needs of males (Frisch, Herzog, & Franko, 2006). Carlat et al. (1997) studied 135 male patients with eating disorders treated from 1980 to 1994 in a hospital setting. Results showed that 68% of the men experienced a medical complication and that 30% of patients were hospitalized for medical or psychiatric reasons, over the course of their eating disorder. At 1-year follow-up, data were available for only 54 patients, and these data revealed that 22% were fully recovered, 19% were partially recovered, and 59% continued to struggle with their eating disorder.

Mental health professionals may mistakenly assume that males with eating disorders are more severely disturbed and have a poorer prognosis than females with eating disorders because males with the most severe cases are those who typically seek treatment. Burns and Crisp (1990) found that the following factors related to poor outcome at 4-year follow-up in males with a history of anorexia: a longer duration of illness, older age at onset, low

minimum weight, disinterest in sports, strained paternal relationship, poor social adjustment as a child, and lack of premorbid sexual activity. Research generally is limited on factors predicting poor outcomes among eating-disordered males.

Although studies overall show that being male does not adversely impact treatment outcome, it is still important to design treatment to account for gender given that masculinity may impact men's presenting concerns and ability to manage difficulties (Levant, 1995). In a service utilization study of more than 1,900 patients with eating disorders, women generally had been through more treatment than men across both inpatient and outpatient services (Striegel-Moore, Leslie, Petrill, Garvin, & Rosenheck, 2000). It is possible that treatment specifically focused on men might encourage more males to seek help.

Men and Masculinity

Although males and females struggle with seeking help for an eating disorder, both may feel more comfortable seeking treatment for a weight concern rather than an eating problem (Hay et al., 2005). Anorexic males, compared to bulimic males, may be more likely to seek help at the suggestion of a primary care physician or a parent (Carlat et al., 1997). The masculinity literature offers insight into men's help-seeking attitudes and behaviors. Masculinity has been correlated with more negative attitudes toward psychological help seeking, and consequently, males make fewer attempts at seeking help (Mahalik, Good, & Englar-Carlson, 2003). From a masculine socialization perspective, men often perceive that psychological services, which involve reliance on others, admitting a need for help, or recognition and labeling of an emotional problem, as inconsistent with traditional masculinity. In addition, men who experience gender role conflict are less likely to seek help. *Gender role conflict* is defined as a "psychological state where gender roles have negative consequences or impact on a person or others" (O'Neil, Helms, Gable, David, & Wrightsman, 1986, p. 336).

McCreary, Saucier, and Courtenay (2005) found that college males who desired more muscularity experienced greater gender role conflict because of society's standard that they are "successful, powerful, and competitive" and "balancing work and leisure" (p. 91). Men may also try to maintain their weight to cope with gender role conflict related to the challenges of balancing work and family or the challenges of achieving success and power. Eating disordered males with gender role conflict may be less likely to seek help because not only does disordered eating potentially serve as a coping function, but men may feel shame for suffering from a disorder commonly associated with females (Carlat et al., 1997). Therefore, mental health professionals need to be cognizant of a possible relationship between gender role conflict and eating disorders in men.

Generally, males are less likely than females to seek psychological help across nearly all diagnostic categories. Few authors have addressed help seeking among males with disordered eating. For instance, Hay et al. (2005) found that males were less likely than females to seek help for eating disorders in primary care. Some evidence exists that attitudes about eating disorder treatment for men may gradually be changing. Braun et al. (1999) reported an increase in the number of males who sought eating disorder inpatient treatment between 1984 and 1997. Males with eating

disorders may prefer to seek help for a related issue (e.g., depression, social anxiety, or obsessive-compulsive disorder) rather than specifically for an eating disorder (Olivardia, 2007). Similar to those working with females with eating disorders, mental health professionals working with males must evaluate whether to focus on the eating disorder in isolation or on the eating disorder and the comorbid disorder concurrently. Some mental health professionals recommend treating any malnutrition before treating comorbid conditions (Bean et al., 2005).

Psychotherapy With Men

Mental health professionals working with males who suffer from eating disorders may consider gender-sensitive psychotherapies designed to treat men's issues (e.g., Cochran & Rabinowitz, 2003). Gender-based psychotherapeutic approaches capitalize on the positive aspects of male socialization in therapy. Mental health professionals can use men's positive qualities and strengths as a springboard for promoting change. For instance, because men are less likely to seek psychological help than women (Mahalik et al., 2003), a therapist can acknowledge the client's entry into therapy as evidence that he is exercising control over improving his life quality.

In Session With Males With Eating Disorders: Part 1. Assessment

Mental health professionals should ask questions about diet, eating, and exercise behaviors as a standard part of their intake protocol, rather than limiting these questions to times when they suspect their client suffers from an eating disorder. Possible screening questions are informed by the eating disorder literature (e.g., Andersen, 1999a; Varnado-Sullivan, Horton, & Savoy, 2006) and could include (a) changes in weight, eating, and/or exercise habits; (b) heaviest and lightest weight versus ideal weight; (c) recent food intake and appetite (ask client to describe a typical day); (d) intentional dieting or control over food intake or use of supplements; (e) restriction, level of exercise, binge and/or purge behaviors, and whether the client is concerned about these behaviors; (f) concerns about weight, shape, or muscularity; (g) concern over weight loss; (h) history and current use of muscle enhancing supplements, such as steroids.

Although little research has examined steroid use as a possible symptom of eating disorders in men, some studies have shown that men use steroids to improve appearance, muscularity, and body image disturbance. Research suggests steroid use may be comparable to vomiting as a compensatory measure in women with eating disorders (Weltzin et al., 2005). Mental health professionals should also listen for the client's degree of stress and/or perfectionism thought to trigger eating disorder symptoms among males and females (Sassaroli et al., 2005). Recent research suggests adolescent boys with eating disorders may also struggle with anxiety disorders. For instance, Strober et al. (2006) found that adolescent boys and girls admitted to treatment for anorexia showed similarly high prevalence rates of anxiety disorders, and both genders presented with personality traits of anxiety and perfectionism.

Mental health professionals also need to assess for daily smoking, alcohol use, use of pain medication, and chronic pain because

they are correlates of binge eating among men (Reichborn-Kjennerud, Bulik, Sullivan, Tambs, & Harris, 2004). For instance, men may use cocaine to inhibit urges to binge or to stimulate weight loss. Additionally, mental health professionals should assess for changes in sexual desires and functioning, particularly decreases in sexual drive, sexual fantasies, and masturbation found related to eating disorders (Andersen, 1999b). Reduced testosterone levels are proportional to decreases in weight, and decreases in testosterone relate to decreased sexual interest, drive, and performance (Andersen, 1986; Andersen, Cohn, & Holbrook, 2000). Finally, once a mental health professional diagnoses the male client with an eating disorder, he or she should assess whether the client feels shame because he feels emasculated by having an eating disorder.

Mental health professionals may use assessment measures. However, standard assessments were often developed for females and may not appropriately assess muscularity, often the male standard of bodily attractiveness. The Eating Disorder Inventory (Garner, Olmstead, & Polivy, 1983) and the Eating Attitudes Test (Garner, Olmsted, Bohr, & Garfinkel, 1982), which measure disordered eating attitudes and behaviors, are typically used with females but do not assess muscularity-oriented body image concerns (McCreary, 2007). The second edition of the Eating Disorder Inventory is considered one of the best validated measures to assess risk and symptoms of eating disorders among women, and yet it is generally less reliable for men, resulting in slightly lower correlations among other eating disorder measures for men (Spillane, Boerner, Anderson, & Smith, 2004). The Eating Disorder Inventory is still valid for use with men; however, some have added items to existing subscales to increase relevance to men. For instance, Oates-Johnson and DeCourville (1999) revised the Eating Disorder Inventory in order to assess not only desire to lose weight, which is what the original measure assessed, but also men's desire to gain weight and muscle mass. Specifically, they added one item to the Drive for Thinness subscale and four items to the Body Dissatisfaction subscale. They included an additional five items to assess overall weight preoccupation. Moreover, Varnado-Sullivan et al. (2006) revised measures to better assess male body image disturbance by substituting male references for

female references, and emphasizing male body concerns, such as the stomach.

Thus, mental health professionals may consider the measures presented in Table 1, which are unique to men's issues, to assess body image disturbance and disordered eating in males. These measures address an individual's motivation to gain muscle. Mental health professionals should distinguish between muscle dysmorphia and eating disorders, given that it is not only men with eating disorders who struggle with muscularity concerns.

In Session With Males With Eating Disorders:
Part 2. Treatment

The basic principles for treating women with eating disorders also apply to men: work toward weight restoration, disrupt maladaptive behaviors, treat comorbidity, challenge thoughts related to weight and shape, and teach ways to adapt to sociocultural and gender roles (Andersen, 2002). Nevertheless, mental health professionals should adapt treatment to the individual, regardless of the treatment model, while addressing masculinity-related issues (Andersen, 1986). As with female clients, male clients with an eating disorder should be monitored medically by a physician. Mental health professionals may prefer an integrated therapeutic approach, including multidisciplinary care in collaboration with dietitians and psychiatrists. A dietician can offer clients psychoeducation about nutrition and metabolism and behavioral exercises, while the mental health professional works interpersonally with clients. A team approach can also help mental health professionals avoid urging clients to give up their symptoms too quickly. For instance, mental health professionals may feel pulled to encourage their clients to stop abusing steroids or starving themselves. Both males and females with eating disorders struggle with control issues related to weight, shape, and food. As with females with eating disorders, males may feel they are losing a sense of control if they are asked to give up their eating disorder behaviors before they feel ready to make changes. Thus, mental health professionals can benefit from consulting with other professionals to monitor their attachment to their clients (Smart, 2006).

Table 1
Possible Measures to Assess Body Image Disturbance and Disordered Eating in Males

Instrument	Author	Description	Reliability and validity
Drive for Muscularity Scale	McCreary & Sasse (2000)	15 items assess behaviors, perceptions, and attitudes related to pursuit of muscularity	Good reliability and validity
Muscle Appearance Satisfaction Scale	Mayville, Williamson, White, Netemeyer, & Drab (2002)	19 items assess muscle dysmorphia symptoms	Strong reliability and validity
Muscle Dysmorphia Inventory	Rhea, Lantz, & Cornelius (2004)	27 items assess men's attitudes toward their body	Good reliability and strong validity
Male Body Attitudes Scale	Tylka, Bergeron, & Schwartz (2005)	24 items assess men's attitudes toward their body	Good reliability and validity
Body Uneasiness Test	Cuzzolaro, Vetrone, Marano, & Garfinkel (2006)	71 items screen and clinically assess abnormal body image attitudes and eating disorders	Psychometrically sound
Exercise Orientation Questionnaire	Yates, Edman, Crago, Crowell, & Zimmerman (1999)	27 items identify eating disorder risk through assessment of exercise attitudes and behaviors	Strong reliability and good validity

When a man presents for therapy, this may be the first time he discloses his eating disorder. Thus, male clients with eating disorders benefit from having a therapist who collaborates with them on building a strong therapy alliance to promote positive therapy outcomes. Males may feel ambivalent about seeking help (Good, Thomson, & Brathwaite, 2005). If they do not seek help, they will likely feel plagued by weight and shape concerns and may continue to take harmful drugs to gain muscle mass. However, by seeking help, they risk losing time spent exercising, and they will have to reduce steroid use and risk losing muscle mass. As with men with muscle dysmorphia, some men with eating disorders prioritize workouts over anything else (Olivardia, 2007).

Olivardia (2007) suggested ways to treat muscle dysmorphia, which may be applicable to treating males with eating disorders. He recommended that therapists begin therapy by assessing men's ideas about therapy and that they discuss preconceived notions about what therapy can and cannot accomplish. Mahalik et al. (2003) suggested that therapists correct faulty assumptions or modify the structure of therapy to better fit the male client. For instance, if the client fears that the therapist will make him discuss issues that he does not want to share, the therapist can provide more accurate information about the therapeutic process (e.g., reassure him that he is in charge of material discussed in therapy). It is important that the mental health professional explore the client's masculine identity and validate his socialization experiences, including peer influences or significant events related to disordered eating. The mental health professional can inform the client about realistic body images, proper nutrition, and the dangers of steroids and can challenge disturbed body image while examining media images. Issues of client transference to the mental health professional's body and appearance may have to be processed. For instance, a client may compare himself to his therapist, inquire about the therapist's exercise routine, and/or seek the therapist's impression of the client's body type. The therapist should assist the client in becoming aware of the assumptions, thoughts, and feelings the client attributes to the therapist. The client's likely underlying concern and feelings of inferiority should be openly discussed. The therapist can join with the client by reflecting on the detrimental nature of comparison to others.

In addition, Andersen (1986, 1999b) highlighted important considerations for treating men. As mental health professionals explore what purpose the eating disorder serves, they may learn that male clients use their eating disorder to cope with distress. In that case, mental health professionals can discuss with the clients alternative ways of managing challenges. Males with eating disorders may also struggle with identifying and expressing feelings, including sexual feelings related to disordered eating. Males who identify as intellectualized and perfectionist may struggle to build close relationships. Thus, mental health professionals should inform men about sexual and social behaviors and discuss opportunities for role models and socialization, while offering encouragement. Mental health professionals should assess family interactions, communication styles, and family roles that might inform the professional about a male client's eating disorder. For instance, males with eating disorders may adopt the role of a patient in the family. Intervening with the family can also help to prevent relapse. Finally, mental health professionals should include nutritional counseling and should consult with an exercise physiologist to develop an exercise program. Exercises may in-

volve cardiovascular fitness, stretching, and strength and muscle enhancement, which can alleviate men's anxiety and increase their control if they feel distressed without exercise. By increasing men's nutrition, male clients may restore their weight and improve comorbid conditions.

Empirically Supported Treatments

Research is needed to identify empirically supported treatments designed for male clients with eating disorders. Extensive research is available on females with eating disorders. For women, cognitive-behavioral treatment has received the most rigorous support in treating bulimia nervosa with some effectiveness in treating anorexia nervosa. Aside from cognitive-behavioral treatment, interpersonal psychotherapy has also gained empirical support compared to other psychological treatments for bulimia (Wilson & Fairburn, 2007).

A search did not reveal specific studies demonstrating use of cognitive-behavioral treatment or interpersonal psychotherapy for males with eating disorders. However, Mahalik (1999a, 1999b) has adapted cognitive-behavioral treatment and interpersonal psychotherapy for working with men. Mahalik (1999a) provided a framework for using cognitive-behavioral treatment to treat male clients' cognitive distortions in the context of masculine gender role conflict. In addition, Mahalik (1999b) created a model for using interpersonal psychotherapy to assess men's interpersonal relationships. Male clients can identify how their needs for control and affiliation relate to maladaptive interpersonal patterns. For instance, men who rigidly endorse traditional male gender roles (e.g., drive toward physical prowess) may appear dominant in interpersonal relationships. Understanding these interpersonal patterns can inform treatment.

Males can benefit from mental health professionals who have an empathic understanding of men's strengths and who collaborate with men to identify environments that match well with their temperament in order to reduce men's distress (Andersen, 1986). Smart (2006) encouraged mental health professionals to show male clients that the mental health professional is strong enough to handle the client's problems. She suggested that mental health professionals listen carefully and avoid making assertions while being interactive and flexible and balancing warmth without appearing overly sympathetic.

Case Vignette

Steve, a 46-year-old Caucasian married male, was referred to Dr. K., a psychologist specializing in eating disorder treatment. Steve had consulted his family physician about fatigue and insomnia, and the physician had referred Steve to Dr. K. Steve reported that he had a demanding job as an insurance agent but was generally feeling successful in his work and content in his marriage of 19 years. A year ago, Steve had seen the physician for a regular check-up and was encouraged to lose about 10 lb and start exercising regularly to lower his moderately high cholesterol level. He joined a local gym and began exercising with a trainer. He quickly lost 10 lb, then another 10, as he increased his workouts from 1 hr three times a week to 3 hr daily. He competed in his first triathlon and described feeling "incredibly strong" afterward. As his weight began to drop further, however, he reported feeling

weaker. He then began to explore options for weight supplements, reduced his cardio workouts, and increased the weight-bearing exercises. As a result, he regained about 6 lb in the form of muscle mass. The physician determined that Steve’s body mass index was within the normal range for men.

Steve’s wife had become concerned that he was working out too much. She had also noticed that he shifted from a regular, balanced diet to a protein-rich, low-carbohydrate diet that he charted obsessively in a book that he carried with him everywhere he went. When she pointed out his preoccupation with food and exercise, he brushed her concern aside with the words “I have never felt better in my life.” Nevertheless, his mood had become erratic in the past 2 to 3 months, his sleep was fitful, and he felt tired and irritated most of the time.

Steve went to see a physician about his symptoms. The physician diagnosed mild anemia and prescribed an iron supplement that improved Steve’s iron level within a few weeks. However, Steve’s physical, cognitive, and emotional symptoms persisted, and on the urging of the primary care physician, he begrudgingly decided he would “work with a psychologist to fix his stress.” Steve came to his initial consultation with Dr. K uncertain about the referral reason but determined to “get this fixed” and “be done.” When Dr. K assessed his diet and exercise behaviors, use of supplements, and high anxiety level regarding these issues, Steve at first resisted these questions. By joining with Steve about his discomfort and by using language that mirrored Steve’s problem-focused approach, Dr. K was able to build rapport. Steve then willingly engaged in more formal assessment of his symptoms and was given the Exercise Orientation Questionnaire (Yates, Edman, Crago, Crowell, & Zimmerman, 1999) and the Body Uneasiness Test (Cuzzolaro, Vetrone, Marano, & Garfinkel, 2006). Results revealed that Steve had a very poor body image and that his attitude and approach toward exercise were unhealthy. He instantly felt ashamed about being diagnosed with an eating disorder. He showed anxiety about how to cope with “losing the gain” (muscle) he had made from excessive exercise. Steve was referred to an exercise physiologist and a dietician who worked with him to slowly taper his workouts while adjusting his food intake.

These behavior changes created intense anxiety for Steve, which was addressed by anxiety management strategies. Early in therapy, body image became a focal point. Steve was assisted in exploring underlying schemata for his eating disorder, such as his need to be viewed as competent, his ideas about midlife changes, and a potential loss of his role in the family. Cognitive-behavioral techniques were used to combat Steve’s dichotomous thinking regarding exercise and “good versus bad” foods. Dr. K and Steve discussed charting his “victories over the eating disorder,” and he completed behavior management charts focused on healthy thoughts and behaviors.

The client also struggled with secrecy. This led to a session with his wife where she shared her concerns and hopes for him. Steve talked at length with her about his anxiety and obsessive thoughts regarding his body image and exercise. Steve’s wife agreed to stop nagging him about his food intake and exercise routine and to instead reinforce healthy behaviors and attitudes.

With behavioral symptoms and anxiety somewhat controlled by Week 6, Dr. K and Steve explored his fear of change and the anticipated loss of self-esteem. Steve realized that he had focused on his body in order to control changes in his life he felt he could

not manage directly. Steve discussed ways to reconfigure his life at this point, and he set new goals for himself that were unrelated to physical and dietary changes. He decided to cut back on his job and instead spend more time with his family and friends. He continued to stay active but with a balanced approach to exercise and diet and an awareness that he needed to deal with the “real problem” instead of changing his body. Therapy ended after a total of 14 sessions over the course of 4 months.

Case Discussion: A Gender-Based Course of Therapy for Eating Disorder Recovery

Assessment

In this case, the psychologist integrated a typical course of eating disorder treatment with principles of psychotherapy with men. Although there are many similarities between eating disorder treatments for males and females, the following were some key differences, as indicated in Table 2. First, Steve was diagnosed with eating disorder not otherwise specified because, to date, there is not another eating disorder diagnosis specifically geared toward the male experience of eating pathology. Issues relevant during this first stage of treatment were differences in presentation of eating disorders in men versus women, a need for sound screening instruments for men, and more discomfort with help seeking by males. Although Steve’s difficulty with eating disordered behaviors was set in motion by his attempt to lose weight per doctor’s orders, he did not experience the drive for thinness that is more typical for women. His concerns were with achieving a better body image and improving his strength. Second, Steve experienced the illness as ego dystonic after he was informed about the meaning of his symptoms. Women are more likely to be conditioned toward a drive to thinness and may experience symptoms as ego syntonic. Screening instruments were chosen for a focus on male body image attitudes and the drive to exercise. The psychologist quickly recognized Steve’s resistance to seeking psychological help and worked on gaining credibility with him by providing information and psychoeducation.

Table 2
Assessment and Treatment Considerations Unique to Men That Were Emphasized in the Case Vignette

Assessment
Diagnosis of eating disorder not otherwise specified
Difference in presentation
Screening instruments focused on male body image attitudes and drive to exercise
Greater discomfort with help seeking
Lack of the drive for thinness that is more typical for women
Desire for a better body image and improved strength
Illness experienced as ego dystonic rather than ego syntonic
Treatment
Treatment goals were set collaboratively to enhance active participation
Treatment goals were concrete and manageable
Treatment focused on Steve’s strengths, perfectionism, societal standards for body image, and achievement expectations for men
Sessions revolved around measurable change in symptoms and behaviors

Treatment

Multidisciplinary outpatient therapy (Smart, 2006) with visits to an exercise physiologist and dietician was chosen as the best treatment option because Steve was physically well and had a good support system. Goals of treatment were set collaboratively with Steve to enhance his active participation. Men tend to respond better when the focus is on their strengths and treatment goals are concrete and manageable. Cognitive-behavioral strategies were applied with special attention to the experience of perfectionism, societal standards for body image, and achievement expectations for men. Progress in therapy was based on a good working alliance between Steve and the therapist. Sessions revolved around measurable change in symptoms and behaviors. Trusting his therapist, Steve ultimately addressed his self-concept, the shame he was experiencing, and his efforts to control his midlife transition.

Conclusion

Males with eating disorders, when compared to females with eating disorders, are often overlooked but are gaining increasing attention. Although there are many similarities between males and females who struggle with eating disorders, there are important differences in males that affect treatment. Mental health professionals should consider a gender-based approach to eating disorder recovery by collaborating with males to understand ways masculinity influences their disordered eating and their decision to seek help.

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Received December 13, 2006

Revision received January 2, 2008

Accepted January 7, 2008 ■

Correction to Elman and Forrest (2007)

In the article, “From Trainee Impairment to Professional Competence Problems: Seeking New Terminology That Facilitates Effective Action,” by Nancy S. Elman and Linda Forrest (*Professional Psychology: Research and Practice*, 2007, Vol. 38, No. 5, pp. 501–509), the APA ethics code standards for issues related to training were incorrectly identified in the last sentence on p. 501 (and continuing on p. 502). The sentence should read as follows: “The 2002 revision of the APA ethics code added standards that address training, including due process conditions for requiring disclosure of personal information when problems arise for trainees (Standard 7.04) as well as standards for mandating individual or group psychotherapy (Standard 7.05).”

DOI: 10.1037/0375-7028.39.4.471