Chapter One

Psychosocial influences on male adolescents' concerns about eating and body shape: a review of the literature.

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(See appendix A for notes to contributors)

1. 0 Abstract

Ten peer reviewed journal articles examining the separate and combined influences of peers, media and parents on male adolescents' concerns regarding eating and shape are critically reviewed. Male adolescents' concerns about eating and body shape were found to be more influenced by parents than either by peers or the media. In the studies reviewed, significant methodological issues were found. The quantitative measures used were often designed for females and therefore did not take into account males' desire to increase muscularity. Where researchers attempted to amend these scales for male adolescents, the reliability and validity of these 'new' measures is unclear. Further limitations include the limited use of qualitative and longitudinal designs and a reliance on participants self-reported height and weight to calculate Body Mass Index (BMI, Cole, Bellizzi, Flegal, & Dietz, 2000). Recommendations for future research include the specific study of male peer groups, those male adolescents heavily involved in sports and the use of longitudinal designs and qualitative methodologies in order to better capture the complexity of psychosocial influences.

1.1 Introduction to Literature Review

In the past forty years there has been a significant increase in the psychological study of body image concerns, (Grogan, 2008). For example, the number of articles addressing body image and body dissatisfaction in the PsychINFO database increased from 726 in the 1970s, to 2,477 in the 1990s, (Cash, 2004). Body image is now recognised as an important aspect of social and emotional development for adolescents.

The majority of the research conducted to date has focussed on female body image concerns. However, evidence today suggests that the number of men accessing eating disorder services has increased significantly over the past decade (Royal College General Practitioners, 2011) and male concerns are often evident in adolescence, Crisp, Burns, Bhat (1986). For example, male adolescents are increasingly displaying a preoccupation for a trim, muscular appearance (Ricciardelli & McCabe, 2011). Evidence suggests that unlike females, male body shape concerns are associated with specific body change behaviours, i.e. use of supplements and steroids in order to increase muscularity. These behaviours have been found to increase susceptibility to eating disorders or associated mental health conditions (Phillips & Castle, 2001).

Eating disorder symtomatology in men has been shown to be under-recognised by GP's (Flahaven, 2006). Therefore a greater understanding of the influences on male adolescent body shape concerns would increase awareness of those at most risk of developing concerns and better inform both the diagnosis and treatment.

The risk factors for developing body image difficulties fit broadly into two categories: those arising out of the cultural context, i.e. influence of peers, family and media, and individual factors, i.e. predisposition for anxiety and depression. Research suggests that unlike the individual factors, exposure to socio-cultural factors alone can be enough to generate body image difficulties, (Grogan, 2008). Grogan (2008) goes on to suggest that individuals have a key reference group (friends, family, media) from which they receive information relevant to body image, arguing that, 'since body image is socially constructed it must be investigated and analysed in its social context', (page 4).

1.2 Aims of Literature Review

The present review will critically evaluate the literature investigating the impact of peer, parental and media influences on male adolescents' concerns about eating and body shape. Clinical implications for male adolescents and areas for further research will be discussed.

1.3 Literature Search Strategies

Three strategies were used to establish relevant literature. Firstly, three major databases (PsycINFO, MEDline and Web of Science) were searched for peer-reviewed published literature. The specific search terms used were: adolescents, boys, male, men, eating disorders, eating beliefs, eating and body concerns. Various combinations of these terms were also used to search the three databases. The researcher attempted to keep the search terms as broad as possible in order to increase the number of potential studies that could be included due to the comparative lack of literature on eating concerns in male adolescents.

The term 'binge eating' is used extensively in the wider eating disorder literature. The term was not included in this present review, however, as evidence suggests that binge eating is difficult to define in male adolescents and is unlikely to be self-reported by male adolescents as an issue. For example, Baker, Maes, Lissner, Aggen, Lichtenstein & Kendler (2009) found that male adolescents are likely have differential thresholds for expressing disordered eating. Other research indicates that 15 to 17 year old boys commonly consume large quantities of food and are less likely than female adolescents to label this a ' binge' or to report feeling out of control during food consumption (Eiben, 2007; Katzman, Wolchik, & Braver,1984; Carlat & Camargo, 1991; Lewinsohn, Seeley, Moerk & Streigel-Moore, 2002).

Secondly, in order to ensure that there were no relevant papers missed by the first search, a more broad-based search of the aforementioned

databases was carried out using the terms adolescence and eating disorders. Non-empirical theoretical papers were excluded.

The final search strategy involved scanning the sources identified in the initial search of the databases for any citations of other relevant studies and these papers were then collected. This literature search took place between August 2010 and March 2011.

Criteria for Inclusion

A total of ten papers met the following inclusion criteria for this study;

- **Male sample**

Studies were excluded if they comprised a totally female sample. Of the ten studies reviewed here eight included male and female adolescents and two studies used an all male adolescent sample.

- **Adolescence**

The literature review focused on male adolescents; of the ten studies, the age range of participants was between 10-18 years old. Studies were excluded from this literature review if they contained participants under the age of ten or over the age of eighteen years old. Research suggests that adolescence is the period of greatest vulnerability to body image concerns and eating disorder symptomatology, (Ackard & Petersen , 2001, Grogan, 2008, Hudson, Hiripi & Pope, 2007). McCabe, Ricciardelli & Banfield (2001)

suggested the onset of puberty in male adolescents leads to their use of strategies, e.g. food supplements and steroids to increase muscularity.

- **Retrospective Methodology**

Studies that relied on retrospective methodology were excluded due to criticism that their findings are subject to bias, due to their reliance on participants' memory, leading to questions over their validity and reliability. Furthermore, Snelgrove & Havitz, (2010) suggested that, 'issues of error and bias can occur due to impression management and identity preservation'. (page 341).

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Influence of Peers.

Title	Design	Measures	Sample	Findings	Critique
Eisenberg & Neumark-Sztainer (2010). Friends' Dieting and Disordered Eating Behaviours Among Adolescents Five Years Later: Findings From Project Eating Amongst Teens (EAT).	Quantitative.	Participants asked whether friends "diet to lose weight or keep from gaining weight". 4 disordered eating behaviours assessed at 2 time points; chronic dieting, unhealthy weight control, extreme weight control, and binge eating. Body Mass Index (Cole, Bellizzi, Flegal, & Dietz, 2000) based on self-reported height & weight. Parental influence based on 'My parents diet to lose weight or prevent weight gain'.	2,516 High-school students (1130 male & 1386 female) from 31 schools in Minnesota. Surveys completed at baseline (1998–1999) when sample aged 12-14 years. Re-surveyed by post in follow-up (2003-2004) when sample aged 15-18 years old.	Among boys, higher rates of friends' dieting associated with extreme weight control behaviours. A strength of this study is that it is among the first longitudinal studies to demonstrate the influence of friends on disordered eating behaviour in a large and diverse sample.	Friends' involvement in dieting based on a single item from the participants self-reports of friends' behaviour are likely to be coloured by an individual's own behaviours and not a reliable measure (Prinstein & Wang, 2005, Ianotti & Bush, 1993). Project Eating Amongst Teens (EAT) didn't include measures of muscle-enhancing behaviours common among males. Body Mass Index (Cole et al, 2000) was based on self-reported height and weight measures therefore open to inaccuracy.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Influence of Peers (continued).

Title	Design	Measures	Sample	Findings	Critique
McCabe, Ricciardelli & Finemore (2001). The Role of Puberty, Media and Popularity with Peers on Strategies to Increase Weight, Decrease Weight and Increase Muscle Tone Among Adolescent Boys and Girls.	Quantitative.	Body Image and Body Change Inventory (Ricciardelli & McCabe, submitted for publication in 2001 accepted 2002). Pubertal Development Scale (Petersen, Crockett, Richards, & Boxer, 1988) Self-Description Questionnaire II (Boyle 1994) used to asses perceived popularity with peers.	1185 adolescents (527 males, 598 females) aged 12-15, drawn from six high schools in Melbourne, Australia. Participants were largely Caucasian (83%).	Findings suggested boys were more likely to adopt strategies to increase muscle tone. For boys, the main predictors of body change strategies were puberty and to a lesser extent, perceived popularity with peers. This study suggests the importance of further research of exercise to achieve ideal body shape and the focus for exercise for this not just to be limited to losing weight.	The role of media, perceived popularity with peers and pubertal development in predicting body dissatisfaction & body change requires further investigation as this study suggests that these variables played a limited role. More research on the use of exercise to alter body shape required. The largely Anglo-Saxon (83%) sample therefore limits generalisability of findings. Sample size listed incorrect as 527 + 598 =1125 not 1185.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Influence of Peers (continued).

Title	Design	Measures	Sample	Findings	Critique
Rancourt & Prinstein (2010). Peer Status and Victimisation as Possible Reinforcements of Adolescent Girls and Boys' Weight-Related Behaviours and Cognitions.	Quantitative.	At two time points, approximately 11 months apart measures assessed body dissatisfaction, negative weight-related cognitions, weight management behaviours, muscle gaining behaviours, likeability, popularity and victimisation. Girls completed the Ideal Body Subscale (IBS-Female; Cogan, Bhalla, Sefa-Dedeh, & Rothblum, 1996). Boys completed the IBS-Male (Cogan et al., 1996), consisting of a similar set of 12 silhouettes ranging from very thin, to muscular, to very obese males.	626 participants at time 1, age range 10-14 years. (50% male sample). At time 2, 567 participants remained, The participants were enrolled in public schools within a city of fairly homogeneous middle-class socioeconomic status in Northeast Carolina, USA.	For male adolescents higher level of body dissatisfaction associated longitudinally with increases in negative body-related cognitions. Findings suggested that both unpopular and highly popular adolescents at greater risk of weight-related behaviours than other adolescents.	Researchers acknowledge that the brief screening instruments used did not provide as thorough an assessment of weight related construct. It is unclear what the gender mix of remaining sample at stage 2 was. Sample had lower prevalence of obesity (20%) than national rate (30%; Ogden, Carroll, & Flegal, 2008). Study examined early adolescence. Important to explore peer status influence during later adolescence.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents ' Concerns About Eating and Body Shape.

Influence of Peers (continued).

Title	Design	Measures	Sample	Findings	Critique
McCabe, Ricciardelli & Banfield (2001). Body Image, Strategies to Change Muscles and Weight, and Puberty: Do They Impact on Positive and Negative Affect Among Adolescent Boys and Girls?	Quantitative.	Body Image & Body Change Inventory (Ricciardelli & McCabe, submitted in 2001 accepted in 2002). Pubertal Development Scale (Petersen, Crockett, Richards, & Boxer, 1988). Depression, Anxiety, and Stress Scale (DASS) (Lovibond & Lovibond, 1995). Positive Affect and Negative Affect Scale (PANAS; Watson, Clark, & Tellegan, 1988). Participants' BMI, (Cole, et al 2000) based on self-reports of height and weight.	1185 adolescents (587 males and 598 females, age range 12-16. Participants from six schools in Melbourne, Australia.	BMI impacted on body dissatisfaction and use of body change strategies in boys. BMI directly predicted strategies to decrease weight among boys. The onset of puberty led to an increased use of strategies to increase muscle tone and use food supplements for boys. As boys attempt to achieve the body type valued by peers and society they aim to increase their muscle size often using food supplements. This process increased levels of anxiety.	Self-report measures of height and weight were used for BMI; therefore this is subject to inaccuracy. No qualitative methodology to the study, richness of the clinical data is therefore limited. Limited cultural diversity of the sample as 83% of respondents were Caucasian. Appears to be the same sample used in this study and in McCabe, Ricciardelli & Finemore (2001) but no reference made to this in paper.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Influence of Media.

Title	Design	Measures	Sample	Findings	Critique
Hargreaves & Tiggemann (2004). Idealized media images and adolescent body image "comparing" boys and girls.	2 x 2 between subjects experimental design.	Visual Analogue Scales (VAS, Hargreaves & Tiggemann,2004). Measures of body dissatisfaction and mood. Participants completed this 5 min before and after viewing commercial. State appearance comparison, a series of self-report items, based on Tiggemann & McGill (2004). The Appearance Schemas Inventory (ASI) (Cash & Labarge, 1996).The Physical Appearance Comparison Scale (PACS, Thompson, Heinberg & Tantleff, 1991). 3 videotapes each containing 18 commercials from Australian television. 1st, 'thin-ideal'. 2nd, 'muscular-ideal'. 3rd not epitomising either thin or the muscular idea.	595 students (310 girls, 285 boys) from two South Australian schools of medium socio-economic status. Students had a mean age of 14.3 years.	Results indicated exposure to idealised TV commercials had only a limited impact on boys' body image.	Just one media source used i.e. TV commercials, whereas media influences may be much broader than this and over a prolonged period of time than can be captured with a single measure. Many boys feel uncomfortable expressing feelings of dissatisfaction about their appearance (Pope, Phillips, & Olivardia, 2000). Qualitative measures may have enabled boys to describe influence of media on body image in more detail.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Influence of Media (continued).

Title	Design	Measures	Sample	Findings	Critique
Knauss, Paxton, Alsaker, (2007). Relationships Amongst Body Dissatisfaction, Internalisation of the Media Body Ideal and Perceived Pressure from Media in Adolescent girls and boys.	Quantitative.	Body Image Questionnaire, (Clement & Lowe, 1996). Frankfurter Body Concept Scales (FBCS, Deusinger, 1998). Socio-cultural Attitudes Towards Appearance Questionnaire (Heinberg, Thompson, & Stormer, 1995). German translation and modified version of Socio-cultural Attitudes Towards Appearance Questionnaire-3 (Thompson, van den Berg, Roehrig, Guarda, & Heinberg, 2004).	1610 participants (791 girls, 819 boys) aged 14 to 16 years (mean age 14.9 years). Participants were drawn from 58 schools in Switzerland, from a 'wide range of socioeconomic status areas'.	Boys experienced significantly lower body dissatisfaction than girls. Internalised media body ideals and perceived pressure to achieve these ideal to a significantly lesser extent than girls. Knauss, et al (2007) suggested gender differences in exposure to media influence; girls currently being exposed to a greater extent to body ideals in the media than boys.	The ethnicity of the sample is not described. Due to the cross-sectional design of the study, not possible to draw conclusions about the direction of the relationship between the factors investigated. Amended item on the Socio-cultural Attitudes Towards Appearance Questionnaire-3 scale, unclear how this affected reliability and validity.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Parental Influence.

Title	Design	Measures	Sample	Findings	Critique
Vincent & McCabe (2000). Gender Differences Among Adolescents in Family and Peer Influences on Body Dissatisfaction, Weight Loss and Binge Eating Behaviours.	Quantitative.	Body Mass Index (BMI, Cole et al, 2000). Multidimensional Body Self Relations Questionnaire (Cash, 1994). Drive for Thinness (DFT) scale from the Eating Disorder Inventory (EDI; Garner, 1991). The Dutch Eating Behaviour Questionnaire (DEBQ; Van Strien, Frijters, Bergers, & Defares, 1986). The Bulimia Test-Revised (BULIT-R; Thelen,Mintz,Vander Wal, 1996).	603 adolescents (306 girls, 297 boys aged 11-18) drawn from 4 private schools in Melbourne, Australia. No specific data about different cultural groups were identified.	Boys found to be more satisfied with their body, similar to previous findings (Keel, Fulkerson & Leon, 1997). Gender differences in bingeing, bulimic tendencies, & normative weight loss were found. If weight gain or increase in muscle size was explored, fathers may be found to have a greater influence on attitudes and behaviours in boys.	Study excluded behaviours more relevant to adolescent boys, i.e. exercise, for increased muscle size. Sample taken from four private schools. Therefore socio-economic diversity likely to be limited. The term 'parental encouragement' not defined clearly. Future research needs to use longitudinal designs to focus on the range of body modification behaviours that are employed by adolescents.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Combined Studies.

Title	Design	Measures	Sample	Findings	Critique
McCabe, Ricciardelli, & Holt, (2010). Are There Different Socio-Cultural Influences on Body Image and Body Change Strategies for Overweight Adolescent Boys and Girls?	Quantitative.	Body Image and Body Change Questionnaire (Ricciardelli & McCabe, 2002). Pubertal Development Scale (PDS, Petersen, Crockett, Richards, & Boxer, 1988). Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988). Body Change Questionnaire (McCabe & Ricciardelli, 2001). Students self-reported or self-measured their height and weight in order to calculate their BMI (Cole Bellizzi, Flegal, & Dietz, 2000).	590 students (344 boys & 246 girls) from Melbourne, Australia (age range 11-16). Underweight boys and girls were excluded from the study.	Boys reported higher scores than girls on body importance, strategies to increase muscle bulk, positive affect and perceived pressure from parents and peers to increase muscle bulk. Overweight adolescents perceived greater pressures from parents and peers to lose weight than normal weight adolescents.	Sample lacked cultural and socio–economic diversity limiting the generalisability of findings. Self-report or self-measure of height and weight, may cause reliability issues. As underweight participants excluded, how socio-cultural messages differ for underweight, adolescents unknown. Perceived pressure from parents and perceived pressure from peers to lose weight scales were combined. However Stanford & McCabe (2005), suggest that there are clear differences between the influence of parents and peers.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Combined Studies.

Title	Design	Measures	Sample	Findings	Critique
Stanford & McCabe (2005). Socio-cultural influences on adolescent boys' body image and body change strategies.	Quantitative.	Socio-cultural Influences on Body Image and Body Change Questionnaire (McCabe & Ricciardelli, 2001b). The Body Satisfaction and Body Change Inventory (Ricciardelli & McCabe, 2002) were used as an outcome measure.	362 boys between to 12-14 years. Drawn from five schools in Melbourne, Australia	Parental messages and to a lesser extent messages from male friends found to be the strongest predictors of body change strategies in adolescent male sample. Findings support previous research that parents significantly influence strategies to decrease weight, particularly mothers (Thelen & Cormier, 1995).	Future research needs to explore the relative influence of perceived messages versus actual messages. The ethnic and cultural diversity of participant sample not listed, therefore unclear how generalisable the findings of this study are.

Table 1

Studies Examining the Psychosocial Influences on Male Adolescents' Concerns About Eating and Body Shape.

Combined Studies (continued).

Title	Design	Measures	Sample	Findings	Critique
Smolak, Murnen & Thompson (2005). Socio-cultural Influences and Muscle Building in Adolescent Boys.	Quantitative.	Boys asked how frequently in the past year they used exercise in order to build muscles. Media Influence Scale for Adolescents Boys (MISA-B; Haselhuhn et al., 2001). Self-Image Questionnaire for Young Adolescents–Body Esteem subscale (SIQYA-BE; Petersen, Schulenberg, Abramowitz, Offer, & Jarcho, 1984). The Center for Epidemiological Studies Depression Scale (CES–D; Radloff, 1977). Physical Appearance Comparison Scale (PACS, Thompson,Heinberg, & Tantleff, 1991). Parental comments scale combined Perception of Teasing Scale Weight and Teasing Frequency subscale (Thompson, Cattarin, Fowler,& Fisher1995).	383 middle-school boys from rural Midwestern region of USA. Participants predominantly Caucasian (91%,); and ranged in age from 11-16 years (median 13 years).	Substantial number of boys interested in building muscles. More than 50% reported exercising and lifting weights in order to increase muscle size. Parental teasing, peers, and media all appeared to influence this in some way.	Participants (n-183) skipped individual items, as they were told they could do, this may further affect validity. Measures were adapted from those designed for adolescent girls, the validity and reliability of this is unclear. Sample predominantly Caucasian, from rural, midwest USA, limits the generalisability of the findings. Peer pressure was assessed by measures validated on a female sample.

1.4 Rationale for the present review

Research suggests that adolescents are especially vulnerable to body concerns, (Ackard & Petersen, 2001, Grogan, 2008). Eating beliefs and body concerns are particularly significant during the physical and psychological changes that occur during puberty, (McCabe, Ricciardelli & Finemore, 2002).

Research has examined the socio-cultural influences on female adolescents' concerns about body shape and losing weight (e.g., Field, Austin, Camargo, Taylor, Striegel-Moore, Loud, & Colditz , 2005). The role of mothers' concerns (e.g., Furman & Shomaker, 2008), peer influence (e.g., Tremblay & Lariviere, 2009) and the media (Stephens, Hill & Hansen, 1994) have been highlighted as of importance. However, the impact of these psycho-social factors on male adolescents has not been studied extensively. An examination of this existing literature will form the focus of the present review.

1.5 Epidemiology of eating disorders in adolescent males

The male lifetime prevalence of Anorexia Nervosa is estimated to be 0.3%, while Bulimia Nervosa is between 0.5% and 1.5% and Eating Disorder Not Otherwise Specified (EDNOS) is 0.03% (Hudson, Hiripi, Pope, & Kessler, 2007, Beekley, Byrne, Yavorek, Kidd, Wolff & Johnson, 2009). However, data regarding the prevalence rates of eating disorders in male adolescents specifically is more

limited, despite evidence suggesting that eating disorder symptomatology is present. For example, Carlat & Camargo (1997) studied 135 male eating disorder patients between 1980 and 1994. They found the mean age of onset of disordered eating was 19 years with a standard deviation of 7.5 years. Crisp, Burns, Bhat (1986) studied 36 men with a diagnosis of Anorexia Nervosa, the mean age of presentation was 17.1 years old (±3.7). These studies suggest that many men are symptomatic as adolescents.

1.6 Gender specific body shape goals

As research has begun to focus on male eating disorders and body image concerns, clear gender differences in body shape goals have emerged. Compared to female adolescents, male adolescents do not regard low body weight as the primary goal of their dieting efforts; rather, they want to build up lean muscle mass and attain a muscular body (Rosen & Gross, 1987). This clear gender differentiation has important implications to consider when reviewing the literature.

2.0 Influence of Peers

Four of the ten studies identified in the present review explored the influence of peers on adolescents concerns about eating and shape. The first of these is a study conducted by Eisenberg & Neumark-Sztainer (2010). They surveyed 2,516 adolescents (1130 male and 1386 female) between 1998–1999 in Time 1 when

the participants were in grades 7-8 (aged 12-14 years) and at follow-up in Time 2 (2003–2004) when participants were in grades 9-12 (aged 14-18 years). Male adolescents reporting that their friends were very involved in dieting at Time 1 were found to have almost four times the predicted probability of using extreme weight control behaviours at Time 2. Male friends' dieting at baseline were found to be positively and significantly associated with chronic dieting, unhealthy and extreme weight control behaviours i.e. use of diet pills, laxative, diuretics and vomiting behaviours which persisted five years later.

An important finding of this study is that that peer dieting was found to influence male adolescent eating behaviours. This finding prompted Eisenberg & Neumark-Sztainer (2010) to propose that prevention programmes should target male adolescents' peer groups in order to increase likelihood of their effectiveness.

This is the first longitudinal study to demonstrate the influence of peers on disordered eating behaviour in a sample of male adolescents. The use of a longitudinal design allowed for the study of change in these behaviours over several years of adolescence where significant physical and emotional changes take place.

Despite this, there are limitations to be considered. Firstly, the primary independent variable (friends' involvement in dieting) was based on just a single item measure. Friends' involvement over the duration of a longitudinal study is likely to be a complex process that cannot be fully addressed by a single item.

Additionally, the data on friends' dieting was provided by the individual participant rather than the friend, casting some doubt on validity and reliability. Previous research on adolescent substance use and delinquent behaviour suggests that self-reports of friends' behaviour were likely to be influenced by an individual's own behaviour (Prinstein & Wang, 2005; Iannotti & Bush, 1993).

Secondly, the Eating Amongst Teens project (EAT), from which this data were collected did not include any measure of the pursuit of muscularity, which has been found to be significantly more common among adolescent males (Cafri, van den Berg & Thompson, 2006). Eisenberg & Neumark-Sztainer (2010) acknowledged that future research should include a wide variety of body change behaviours that are relevant to both males and females, in order to build on their initial findings.

McCabe, Ricciardelli & Finemore (2001) studied the role of peers' influence, the impact of media and popularity with peers on strategies to alter weight and increase muscle tone among adolescents. Importantly, this study also considered the role of both eating and exercise to achieve body change, rather than focusing simply on eating as previous studies had done. McCabe et al (2001) wrote that they recruited a sample of 1185 adolescents; however, the split of 527 male and 598 female participants detailed in the paper only totals 1125 not the 1185 as stated. This apparent disparity, which remains unexplained in the paper, should be acknowledged when considering the reliability and validity of the findings.

Participants completed the Media and Perceived Socio-cultural Influences subscales of the Body Image and Body Change Inventory (Ricciardelli & McCabe, 2002) Two subscales of the Self-Description Questionnaire II (Marsh, 1988) were used to assess perceived popularity with peers. In addition, two items from the Pubertal Development Scale (PDS; Petersen, Crockett, Richards, & Boxer, 1988) were used to assess pubertal growth.

Male adolescents were more likely than females to adopt both eating and exercise patterns to increase muscle tone and weight. Overall, the results indicated that male adolescents were more satisfied with their bodies. For males, the main predictors of body change strategies were puberty and, to a lesser extent, their perceived popularity with peers. However, there was no significant association found between body change strategies and media influences for male adolescents in this study. Two studies that have specifically attempted to investigate the extent of media influence on adolescent boys are evaluated in the next section of this review.

A strength of this study was that the researchers included measures asking male adolescents about body change strategies most relevant to them, e.g. pursuit of muscularity. The findings suggest that male adolescents attempt to achieve the body form endorsed by society, with less focus on losing weight and more focus on increasing muscle tone. A criticism of this study is that strength of association between body dissatisfaction and various body change strategies was lower than expected, this suggests that there may be other variables not considered in this study that also influence eating and exercise behaviours.

A third study examining peer influence on male adolescents concerns about eating and shape was conducted by Rancourt & Prinstein (2010). They investigated the role of peer status and victimisation as possible reinforcements of adolescent girls' and boys' weight-related behaviours and cognitions in a sample of 567 adolescents (10-14 years).

Rancourt & Prinstein (2010) used measures of body dissatisfaction, negative weight-related cognitions, weight management behaviours, muscle gaining behaviours, Body Mass Index (BMI, Cole et al, 2000), likeability, popularity and victimisation. These measures were administered at two time points, approximately eleven months apart.

In line with expectations, results suggested that higher levels of male adolescent body dissatisfaction were associated longitudinally with increases in negative body-related cognitions. Perhaps more surprisingly, the findings indicated that, as well as less popular counterparts, male adolescents who were highly popular amongst their peers were also at greater risk of weight-related behaviours and cognitions than other adolescents. In an attempt to account for this, Rancourt & Prinstein (2010) proposed that popularity may reinforce a tendency to develop concerns over one's body in order to maintain status. The authors suggested that future research should examine the relationship between popularity and likeability in relation to weight-related concerns.

A strength of this study is that the researchers acknowledge the complexity of this topic by using a longitudinal methodology in order to capture a more accurate

picture of the processes at work for adolescents. A significant limitation of this study is the use of measures that are not specific to male adolescents. The authors acknowledged this as they found the internal consistencies of the weight-related behaviour and cognition measures were stronger for girls than boys on all instruments, with the exception of the measurement of muscle-gaining behaviours. Therefore, the findings reported here may be providing an inaccurate representation of the relationship between peer relations and weight-concerns relevant to male adolescents.

A second limitation is the use of brief screening instruments to examine these complex topics. Other existing instruments (e.g. EDI-3, Garner 2004) have been more extensively validated and may have been more appropriate. A further limitation is that the sample used here had a lower prevalence of overweight/obesity (20%) than the national average of 30% found by Ogden, Carroll, & Flegal (2008), which may have influenced the results.

The final study examining peer influences on concerns about eating and shape in this present review was conducted by McCabe, Ricciardelli and Banfield (2001), who examined the impact of weight loss and muscle tone strategies on negative and positive affect among adolescents. The 587 male participants were aged between 12-16 and were recruited from six high schools in Melbourne, Australia. Participants completed the Body Image and Body Change Inventory (Ricciardelli & McCabe, 2002), the Pubertal Development Scale (Petersen, Crockett, Richards, & Boxer, 1988), the Depression, Anxiety, and Stress Scale (DASS; Lovibond & Lovibond, 1995) and the Positive Affect and Negative Affect Scale

(PANAS; Watson, Clark, & Tellegan, 1988). Participants' self-report measures of height and weight were used to calculate Body Mass Index (BMI, Cole et al, 2000).

McCabe, et al (2001) found that the use of body change strategies predicted increased levels of anxiety and negative affect for male adolescents. In particular, the use of food supplements was a strong predictor of anxiety. The researchers suggested that adolescents use of food supplements highlighted the body dissatisfaction they experienced and this was strongly linked to anxiety.

McCabe et al's (2001) study does highlight the complexity of peer influences on male adolescents. However, given that the study adopted a correlational design, further research is indicated to elucidate the nature of the relationship of positive effect and strategies to change body size and shape. A significant limitation of the study is its reliance on participant-reported measurements of height and weight, which raises questions about accuracy and reliability.

In summary, four studies examining peer influence on adolescents' concerns about eating and shape were reviewed. The influence of peer dieting on disordered eating behaviours in male adolescents was widely reported by male adolescents in these studies. Perceived popularity with peers was also found to be a predictor of body change strategies. As well as less popular male adolescents, highly popular male adolescents were also at greater risk of weight-focused behaviours and cognitions.

Methodological limitations in these four studies include the use of measures that do not take into account boys' drive for muscularity, a reliance on brief screening measures and participants' self-measurement of height and weight. A more rigorous research methodology and greater use of longitudinal research designs is required to explore the complexity of peer influences on concerns about eating and shape.

3.0 Influence of media

Mass media such as magazines, television, social media etc. provide a multitude of opportunities to be exposed to beneficial, as well as potentially harmful messages about body ideals, (Toscano 2011, van den Berg, Thompson, Obremski & Coovert, 2002). Grogan (2008) suggested the images portrayed in the media may be particularly important in producing changes in the ways that the body is experienced and evaluated. Extensive research has shown that exposure to idealised media images leads to increased body dissatisfaction in female adolescents (Groesz, Levine, & Murnen, 2002; Stice, Spangler, & Agras, 2002). However, the study of the impact of media factors on male adolescent body dissatisfaction has largely been neglected.

Two studies investigating the influence of the media on adolescent boys' concerns regarding eating and body shape are considered in this present review. Hargreaves & Tiggemann (2004) examined the effect of viewing idealized images of attractiveness on adolescents' levels of body dissatisfaction. The sample

consisted of 595 South African adolescents (310 female and 285 male). Participants watched television commercials containing images of either ‘thin ideal’ models for girls or ‘muscular ideal’ models for boys; the third set of commercials contained no actors epitomising either the thin or the muscular ideal. Body dissatisfaction was rated prior to and immediately after viewing the advertisement using visual analogue scales (VAS) as a measure of mood state and body dissatisfaction. Participants also completed the Appearance Schemas Inventory (ASI, Cash & Labarge,1996) and the Physical Appearance Comparison Scale (PACS, Thompson, Heinberg,& Tantleff, 1991).

The results indicated that exposure to muscular-ideal commercials did not lead to increased body dissatisfaction in the male adolescents. However, a limitation of this study is that it used just one source of media exposure i.e. television commercials and that the influence of exposure to idealised body images may be something that occurs over a long period of time and therefore a snapshot measure does not necessarily capture the full extent of this. Future studies could address this by using measures that incorporate a broader range of media sources (McCabe, Ricciardelli & Finemore, 2002) over several time points in order to more effectively study of the influence of media exposure on body satisfaction over a more prolonged period of time.

A second study by Knauss, Paxton & Alsaker (2007) examined adolescents’ internalisation of media body ideals and the subsequent perceived pressure to achieve this. The sample of 1610 participants consisted of 819 male adolescents

and 791 female adolescents aged 14 to 16 years, drawn from fifty-eight schools in Switzerland.

Participants completed the Body Image Questionnaire, (Clement & Lowe, 1996), the Frankfurter Body Concept Scales (FBCS, Deusinger, 1998). Internalisation of media body ideals was assessed using the Socio-cultural Attitudes Towards Appearance Questionnaire Internalisation subscale (Heinberg, Thompson, & Stormer, 1995). Perceived pressure to achieve media body ideals was assessed using the Socio-cultural Attitudes Towards Appearance Questionnaire-3 (Thompson, van den Berg, Roehrig, Guarda, & Heinberg, 2004). This scale was modified to take into account the muscular ideal for boys. Instead of being asked if they felt pressure from the media to diet, male participants were asked if they felt pressure from the media to have a muscular, hairless body. Results indicated that male adolescents experience significantly lower body dissatisfaction and perceived pressure to achieve body ideals than girls. These gender differences in body dissatisfaction are consistent with other studies (Barker & Galambos, 2003; Eisenberg et al., 2006).

Knauss et al (2007) suggested the findings may be as a result of adolescent males being exposed to fewer images of body ideals in the media than female adolescents, (Strahan, Wilson, Cressman, & Buote, 2006). This explanation is partly supported by research showing that there are more diet and muscle development features and advertisements in women's than in men's magazines (Andersen & DiDomenico, 1992).

There are a number of criticisms of the design of the Knauss et al (2007) study that need to considered. Firstly, due to the cross-sectional design of the study, it is not possible to draw conclusions about cause and effect between two variables or the direction of the relationship between the factors investigated. Secondly, as the ethnicity and socio-economic status of participants were not reported, it is unclear if cultural differences were present in the sample. Thirdly, in an attempt to make the Socio-cultural Attitudes Towards Appearance Questionnaire-3 more applicable for male adolescents, the researchers amended an item on the scale, however, the comparability of these subscales has not been confirmed. As this study is now five years old, research is needed in order to evaluate this same question again in an attempt to find if the exposure to male idealised body images has increased.

In summary, two studies investigating the influence of media on adolescent boys' concerns regarding eating and body shape found that media had no significant influence on male adolescent concerns. The influence of media on adolescents is difficult to assess, partly because engagement with media varies between individuals. Larson (1995) suggested that media usage changes, often becoming more individualistic as adolescents grow older they begin to develop their own sense of self in an attempt to separate from their parents. Malamuth & Implett (2001) suggested that individual personality factors may also be important, as research suggests that the type of media people select and find gratifying is predictably related to their personalities and individual differences. Furthermore, certain moderating variables such as family environment and parental influence

may be significant (Malamuth & Impett, 2001) and require longitudinal investigation in order to attempt to account for the complexity of these factors over time.

4.0 Parental Influence

The significance of the parent-child relationship in the aetiology of disordered eating in females has been extensively researched (Bruch, 1973; Callam, Waller, Slade, & Newton,1990;Ward,Ramsey, & Treasure, 2000). For example, maternal over-protectiveness has been significantly associated with Anorexia Nervosa (Strober & Humphrey, 1987). The impact of parental relationships on male adolescents' concerns about eating and shape has not been explored. This appears to be a significant oversight, since family relationships have been found to be important for long-term treatment outcome (e.g. Strober, Freeman, & Morrell,1997).

Only one study examining parental influence on male adolescent concerns about body and shape met the inclusion criteria for the present review. Vincent & McCabe (2000) examined perceived family and peer influences on body dissatisfaction, weight loss and binge eating behaviours in adolescents. The authors recruited 306 female and 297 male adolescents from schools in Melbourne, Australia. Participants completed the Multidimensional Body Self Relations Questionnaire (Cash, 1994), the Drive for Thinness scale from the Eating Disorder Inventory (Garner, 1984), the Restraint Eating Scale from the Dutch Eating Behaviour Questionnaire (Van Strien, Frijters, Bergers, and

Defares, 1986) and the Bulimia Test-Revised (Thelen, Farmer, Wonderlich, and Smith, 1991). Four measures were used to assess the quality of family and peer relationships, (see Table1 for further details). Participants' height and weight measurements were taken and used to calculate BMI (Cole et al, 2000).

The study found that male participants were more satisfied with their bodies and less likely to engage in extreme weight loss behaviours than female participants. Parental and peer influences were shown to predict body dissatisfaction and disordered eating across gender. However, adolescent boys' perceptions of relationships with fathers only played a role in predicting more severe forms of eating problems. This observation is consistent with previous research findings (Eme and Danielak, 1995; Striegel-Moore and Kearney-Cooke, 1994; Swarr and Richards, 1996).

A limitation of this study is that the sample was taken from four private schools. Ideally, studies would incorporate a cross section of socio-economic and cultural diversity to increase the generalisability of findings. Secondly, the term 'parental encouragement' used by Vincent & McCabe (2000) is not operationally defined in sufficient detail.Tthis broad term may include several important parental factors that would benefit from further clarification. It is unclear whether encouragement is simply verbal or is related to other factors, such as parental presence at mealtimes which has been found to be positively associated with adolescents' higher consumption of fruit and vegetables and inversely related to missing breakfast (Videon & Manning, 2003).

Only one study was found that examined parental influence. This study indicates the importance of parental influence on male adolescents' concerns about eating and body shape. Despite there being substantial research of parent-daughter influences on eating, evidence regarding parent-son influences is very limited and more extensive research is required in this area.

5.0 Combined Studies

Due to the inherent complexity of researching individual social-cultural factors separately, a number of researchers have studied the combined influence of socio-cultural factors of peers, parents and media. Three studies were found that combined these three factors and met the inclusion criteria for this present review.

McCabe, Ricciardelli, & Holt, (2010) conducted a cross-sectional investigation of the relationship between socio-cultural pressures and body change strategies of both overweight and normal weight adolescents. The authors examined whether overweight adolescents receive different messages from parents, peers and media regarding weight loss and muscle bulk than normal weight adolescents.

A total of 590 adolescents, (344 boys and 246 girls) aged 11-16 participated; they were recruited from high schools in Melbourne, Australia. The participants were classified as normal weight or overweight according to their BMI (Cole et al, 2000). Of the 344 boys, 268 were classified as within the 'normal' weight range,

and 76 were classified as overweight. Underweight participants were excluded from the study.

Participants completed the following measures: the Body Image and Body Change Questionnaire (Ricciardelli & McCabe, 2002), the Pubertal Development Scale (Petersen, Crockett, Richards, & Boxer, 1988), the Positive and Negative Affect Schedule (PANAS, Watson, Clark, & Tellegen, 1988) and the Socio-Cultural Influences on Body Image and Body Change Questionnaire (McCabe & Ricciardelli, 2001). Students self-reported their height and weight in order to calculate their Body Mass Index (Cole et al, 2000). For those participants who did not know their bodily dimensions, a set of scales and tape measure were provided.

McCabe et al (2010) originally designed separate items in order to assess the perceived pressure from parents and peers to both losing weight and increasing muscle size. However, they described that significant correlations between these items were found and therefore the researchers combined these items into a single scale.

The findings indicated that male adolescents reported higher scores than females, on measures of body importance, strategies to increase muscle bulk, positive affect, messages from the media and perceived pressure from parents and peers to increase muscle bulk.

Overweight male adolescents were found to perceive greater pressures from parents and peers to lose weight than normal weight adolescents. Amongst overweight male adolescents, negative effect was found to be important for predicting weight loss. The authors suggest that the findings of this study demonstrate the central role played by socio-cultural pressures in influencing overweight adolescent boys' effect and strategies to lose weight and or increase muscle bulk.

There are several limitations here. Firstly, the study used a cross-sectional, correlational design, with its inherent limitations. This study also relied on participants' self-reports of their height and weight or self-measurement. Evidence suggests there is likely to be significant underestimation of weight and overestimation of height (Stewart, Jackson, Ford & Beaglehole, 1987). A further limitation is that researchers combined the scales assessing perceived pressure from parents and peers to lose weight, which meant that the study could not tease out differences between parental and peer pressure, whereas other studies, such as Stanford & McCabe (2005), suggest that there are clear differences between the influence of parents and peers. Finally, this study excluded underweight boys and girls and future research could usefully examine how socio-cultural messages and subsequent behaviours differed for underweight adolescents.

A separate study by Stanford & McCabe (2005) investigated socio-cultural influences on adolescent boys' body image and body change strategies. The sample comprised 362 adolescent boys also located in Melbourne, Australia.

Participants completed the Socio-cultural Influences on Body Image and Body Change Questionnaire (McCabe & Ricciardelli, 2001b). This includes a media influences scale and scales to assess feedback from father, mother, best male friend and female friend. Three of the five subscales within The Body Satisfaction and Body Change Inventory were used as a measure of outcome (Ricciardelli & McCabe,2002).

The findings indicated that parental messages had the strongest influence on body image and were one of the strongest predictors of body change strategies, along with the media and to a lesser extent, messages from male friends. The findings are consistent with findings from previous research (Thelen & Cormier, 1995).

Interestingly, Stanford & McCabe suggested that the parental messages to adolescents differed depending on the gender of the parent and were related to the parent's own goals and body change strategies. For example, messages from fathers were found to focus on muscles and messages from mothers about losing weight accounted for most of the unique variance in body change strategies. This finding is supported by Lamb, Jackson, Cassiday, & Priest, (1993) who suggest that fathers are concerned with being muscular and lean, while mothers are concerned with losing weight and becoming slim. Stanford & McCabe (2005) suggest that this highlights the pervasiveness of messages related to increasing muscles among adolescent boys.

A particular strength of this study is that it uses an all male adolescent sample and suggests that parental influences differed according to gender, highlighting the significance of the father-son relationship in male adolescents' concerns about increasing their muscularity.

However, the findings need to be interpreted cautiously as the data were based on self-report. Stanford & McCabe acknowledge this limitation and suggest that future research should examine the relative influence of perceived messages versus actual messages.

The final study examining the combination of socio-cultural influences was conducted by Smolak, Murmen & Thompson, 2005. The sample of 383 school boys from rural Midwestern regions of the United States consisted of predominantly Caucasian (91%) participants aged between 11-16 years. This study in particular focused on the use of muscle building techniques, particularly from food supplements and steroid use.

To assess how boys used strategies to build muscle size, participants were asked how frequently during the past year they had used exercise, weightlifting, eating more, taking vitamins or supplements and steroids in order to build muscles. The authors combined participants' responses from these five items in order to create a total score. The researchers measured media influence, body esteem, depression, social comparison, and peer pressure regarding friends' interest in muscularity. Parental influence was also measured using the Parent

Comments Scale, which included paternal and maternal comment, teasing and influence items.*

Results indicated that a substantial group of adolescent boys were interested in building muscles. Slightly more than half of the sample reported exercising and lifting weights in order to increase muscle size, in keeping with previous findings by Ricciardelli and McCabe (2003a).

In exploring what factors contribute to this, Smolak et al (2005) found that social comparison mediated the influence of media, peers and parents on muscle building. In general, parents' comments were found to be an important correlate of muscle-building techniques, and use of food supplements and steroids. The authors also found that levels of depression were higher for the groups of adolescent boys who used either food supplement or steroids to build muscle. This was suggested to be related to adolescents' dissatisfaction with their body and subsequent low levels of self-esteem.

The findings from this study highlight the important role of all three socio-cultural factors in adolescent boys' use of muscle-building techniques and use of food supplements and steroids. Smolak et al (2005), suggest that adolescent boys are increasingly exposed to pressures to achieve a muscular ideal (e.g. Pope, Olivardia, Gruber & Borowiecki 1999) and these increasing pressures appear to be influencing behaviours in this regard.

* For further details of the measures used please refer to Table 1.

There are some limitations to this study. 183 of the 383 participants skipped individual items, as they were told they could by the researchers, therefore potentially impacting on the validity and reliability of results obtained. Also, as the sample was drawn from a predominantly Caucasian, rural, Midwestern school in the United States, generalisability of the findings is limited.

Three studies examining the combined influence of media, parents and peers on adolescent boys' concerns about eating and shape were reviewed here. Stanford & McCabe (2005) and McCabe et al (2010) found that parental influence appears to provide the strongest and most consistent messages to young adolescent boys about eating and shape. This finding is supported by Smolak et al (2005) who suggest that parents' comments are an important correlate of body change strategies such as muscle-building, food supplements and steroid use in male adolescents.

However, the above studies have several limitations including a reliance on cross- sectional and correlational designs and the use of limited participant samples. Finally, evidence suggests that male adolescents may become more susceptible to certain socio-cultural factors such as the influence of media as they get older, (Hargreaves & Tiggemann, 2004), Sepulveda, Carrobles, Ganarillas, 2010). Therefore, longitudinal research is required in order to investigate this further.

6.0 Clinical Implications

6.1 Greater awareness of body image concerns in male adolescents

Historically, body image concerns have been associated with females. As the present review demonstrates, adolescent boys do experience concerns about eating and shape and there are a number of socio-cultural factors that impact upon this. The difficulty of investigating this topic with adolescent boys has been highlighted by Pope, Phillips & Olivardia, (2000) who argue that although some boys are willing to acknowledge body image concerns, many feel uncomfortable expressing feelings of dissatisfaction regarding their appearance.

Consequently, body image concerns in adolescent boys may be concealed from medical professionals. It is therefore important that medical professionals are increasingly aware of possible body image related problems in adolescent boys referred for other difficulties. For example, Smolak et al (2005), recommend that clinicians seeing adolescent boys presenting with depressive symptoms should consider the possibility of the adolescents' food supplement or steroid use.

6.2 Importance of parental influence

Vincent & McCabe (2000), McCabe, Ricciardelli, & Holt, (2010), Stanford & McCabe (2005) and Smolak, Murnen & Thompson (2005) all suggested that

parents had the greatest socio-cultural influence compared to media and peer influence on adolescents' body concerns and disordered eating. It has been suggested that this may be either parents' presence at mealtimes or their views and behaviours, (Videon & Manning, 2003). Messages from parents are related to their own body goals and body change strategies as suggested by Stanford & McCabe (2005), Lamb, Jackson , Cassidy & Priest,(1993). For adolescent males, Vincent & McCabe (2000) suggested that the perceived quality of relationships with fathers may have a greater influence on attitudes and behaviours on their sons' eating behaviour. Further exploration of this is would increase our understanding of parental influence on adolescent males' eating and body concerns. Previous research into parental influence on adolescent girls has found that daughters' desire to be thinner and dieting behaviour is positively correlated with their parents' reported encouragement of them to control weight.

The influence of parents on male adolescents' body image and eating concerns is a complex phenomenon that needs to be explored in more depth. For example, longitudinal studies would capture any changes in the influence of parents over time as the adolescent develops.

6.3 Preventative programmes for those heavily involved in sports

Smolak, et al (2005) suggested that eating disorder prevention programmes, similar to those for female adolescents (e.g., Levine & Smolak, 2001, 2005),

should be designed to attempt to reduce the number of adolescent males engaging in potentially dangerous body change behaviours. It has been suggested that male adolescents involved in sporting activities are likely to be most at risk as they attempt to balance fitness for sport against unhealthy exercising and use of food supplements or steroids (Smolak et al, 2005). This argument is supported by Crisp, Burns and Bhat (1986) and Langley (2006), who suggest a link between male adolescents who have athletic prowess, are heavily involved in sports and strive for physical perfection, and the development of eating disorders. Smolak et al (2005) suggested that sports coaches are a particularly important audience for this message and as part of preventative measures should monitor signs of unhealthy over-exercising or dangerous use of supplements.

6.4 Preventative Programmes' focus on peer groups

Research has suggested that the identification and prevention of body image concerns in adolescent boys should focus not just on individuals but on peer groups. Several of the studies reviewed here have highlighted the importance of peer influences in concerns about eating and shape.

Eisenberg & Neumark-Sztainer (2010) found peer dieting influenced disordered eating behaviours amongst male adolescents. Smolak et al (2005) found that the male friends of boys who have concerns about their body shape are most at risk of going on to develop disordered eating attitudes and behaviours. McCabe,

Ricciardelli & Finemore (2001) suggested that one of the main predictors of body change strategies for adolescent males was their perceived popularity with peers. Interestingly, Rancourt & Prinstein (2010) went onto suggest that both highly popular and less popular adolescents were equally vulnerable to developing a greater risk of weight-related behaviours as other adolescents. These studies highlight the importance of conducting further research to increase our understanding of the influence peers have on male adolescents' concerns about eating and shape.

7.0 Recommendations for further research

7.1 Accurate reporting of height and weight.

Two of the studies reviewed asked participants to self-report or self-measure height and weight. Empirically, this is a confounding variable as evidence suggests there is a tendency to significantly underestimate weight and overestimate height, (Stewart, Jackson, Ford, & Beaglehole, 1987). In order to increase reliability and validity of future studies of adolescents' body shape concerns, objective measures of height and weight should be used.

7.2 Methodological Limitations

The majority of studies in this present review relied on quantitative measures collected data at a single time point. The use of cross-sectional quantitative methodology is likely to miss the important richness that qualitative longitudinal

data could provide. Only two studies (Eisenberg & Neumark-Sztainer, 2010 & Rancourt & Prinstein, 2010) of the ten critically reviewed collected data at several time points. Longitudinal studies of the socio-cultural influences on adolescent boys' concerns about eating and shape are of particular importance in light of research findings suggesting that the influence of puberty and media may impact on adolescent boys at later time periods than female adolescents, (McCabe, et al 2002, Sepulveda, Carrobles, & Ganarillas, 2010).

As previously mentioned, several studies reviewed here used a correlational research design. An advantage of these designs is that they are easy to conduct and are valuable where it is difficult or impossible to directly manipulate a variable, e.g. gender or age. However, correlational designs have been heavily criticised (Games, 1990) as they do not allow direct causal links to be inferred. In the study of the complexity of socio-cultural influences, there are many other possible explanations for the relationship. Therefore the use of this methodology, although often convenient for researchers, does not advance our understanding of this topic.

7.3 Appropriate measures for male adolescents

Three of the studies reviewed (Rancourt & Prinstein, 2010, Eisenberg & Neumark-Sztainer 2010, Vincent & McCabe, 2000) used eating disorder measures that were originally designed for use with female participants and not extensively validated for use with male participants.

There is a lack of appropriate measures applicable to male adolescents. For example, widely used Eating Disorder Inventory (EDI, Garner, 1984) does not assess muscle oriented body image concerns (McCreary, 2007). Future research is needed to develop reliable and validated measures to improve the accuracy of measurement of disordered eating and body image in males.

7.4 Culturally diverse samples

Five of the ten studies in this present review are from McCabe and colleagues based in Melbourne, South Australia. Samples recruited for these studies are predominantly Caucasian, from middle class backgrounds and lack cultural, socio-demographic and ethnic diversity. This therefore severely limited the generalisability of the findings to other populations. It is also unclear whether or not some participants have taken part in more than one of the McCabe series of studies. If so, they may have some awareness of the goals of the experimenters possibly causing bias in participant responses. A further limitation is that there appears to be no replication of the McCabe et al's findings in a separate lab. It could be argued that as 50% of the studies used in this literature review were from the same researchers this may be an argument for a broader set of search terms being used. Future research should therefore aim to recruit more diverse samples, thereby increasing generalisability of findings.

7.5 Study of Pre-adolescent males

As discussed in the criteria for inclusion (page 18) this present review used studies of samples of adolescent males (10-18 years old) only. This was because research suggested that adolescence was the period of greatest vulnerability to body image concerns and eating disorder symptomatology, Ackard & Petersen, (2001). However, Ricciardelli, McCabe, Mussap,&. Holt, (2009) suggest 'studies that track the development of boys' body-image concerns from a young age through adolescence are needed, this will assist us in designing prevention programs to address the development of problem behaviours before adolescence.' (page 89). This proposal is supported by research by Richards, Casper Larson (1990) which found that weight and eating concerns were evident in pre-adolescents between 6 and11 years old. It therefore appears important for future research to include the study of pre-adolescent children in future research in order to get a fuller picture of concerns about eating and body shape.

8.0 Summary and Conclusions

Research investigating adolescent boys' concerns about eating and shape is at present not extensive and the existing studies reviewed have several empirical limitations. The research that has been conducted indicates that adolescent boys do experience concerns about eating and body shape, with the drive for muscularity being the most prominent of these. The studies critically reviewed here identify parents and peers as having the most influence on adolescent boys,

rather than the media, although the study of media influence is to date very limited.

As there are indications that the number of adolescent boys with eating concerns and the number of men admitted to eating disorder services are increasing (Braun et al, 1999), it is vital that future research addresses this area. Identification of possible precursors of concerns about eating and shape could improve our understanding and inform early interventions for those adolescent males most at risk.

9.0 References (* denotes papers forming the literature review)

Ackard, D.M.,Petersen,C.B. (2001). Association between puberty and disordered eating, body image, and other psychological variables. *International Journal of Eating Disorders. Vol.29,2,pp.187-194.*

Alsaker, F. (1992). Pubertal timing, overweight, and psychological adjustment. *Journal of Early Adolescence, 12,4, pp.396–419.*

American Psychiatric Association.(1994). *Diagnostic and statistical manual of mental disorders* (4th ed). Washington,DC: American Psychiatric Association.

Andersen, A.E., & DiDomenico,L. (1992). Diet vs. shape content of popular male and female magazines: A dose-response relationship to the incidence of eating disorders. *International Journal of Eating Disorders, 11, pp. 283–287.*

Areemit,R., Katzman,D., Pinhas,L., & Kaufman,M. (2010). The Experience of Siblings of Adolescents With Eating Disorders. *Journal of Adolescent Health. 46,(6), pp. 569-576.*

Attie, I., & Brooks-Gunn, J. (1989). Development of eating problems in adolescent girls: A longitudinal study. *Developmental Psychology. 25, pp.70-79.*

Austin S., Ziyadeh N.J., Corliss,H., Rosario, M., Wypij, D., Haines,J., Camargo,C., & Field, A. (2009). Sexual Orientation Disparities in Purging and Binge Eating From Early to Late Adolescence. *Journal of Adolescent Health, 45, 3, pp 238-245.*

Baghurst, T., Hollander, D., Nardella, T., & Haff, B. (2006). Change in socio-cultural ideal male physique: An examination of past and present action figures. *Body Image, 3, 1, pp. 87–91.*

Baker, J. H. Maes, H. H., Lissner, L., Aggen, S. H, Lichtenstein, P., Kendler, K. S. (2009). Genetic risk factors for disordered eating in adolescent males and females. *Journal of Abnormal Psychology, 118,3, pp.576-586.*

Barker, M., Robinson, S., Wilman, C. & Barker, D.J. (2000). Behaviour, body composition and diet in adolescent girls. *Appetite, 35, (2), pp. 161–170.*

Barker, E.T., & Galambos, N.L.(2003). Body dissatisfaction of adolescent girls and boys: Risk and resource factors. *Journal of Early Adolescence,23, pp. 141–165.*

BEAT (2000). Online PDF; Eating Disorders In The U.K. Review Of The Provision Of Health Care Services For Men With Eating Disorders. Retrieved from; www.beat.co.uk/AboutEatingDisorders/Mengeteatingdisorderstoo.co.uk.

Beck, A.T. ,Ward, C.H., Mendelson, M ,. Mock, J., & Erbaugh, J. (1961). An Inventory for Measuring Depression. *Archives of General Psychiatry.4, 6, pp.561-571*.

Beekley, M.D. Byrne, R., Yavorek, T., Kidd, K., Wolff, J., & Johnson, M. (2009). Incidence, prevalence, and risk of eating disorder behaviours in military academy cadets. *Military Medicine,174,(6),pp.637-641.*

Borzekowski,D.L.G., Robinson,T.N., Killen,J,D,(2000). Does the camera add 10 pounds? Media use, perceived importance of appearance, and weight concerns among teenage girls. *Journal of Adolescent Health, Vol. 26,1, pp. 36-41.*

Boyle, G.J. (1994). Self-Description Questionnaire II. *Test Critiques,10, pp. 632-643.*

Braun, D.L., Sunday, S.R., Huang, A., & Halmi, K.A.(1999). More males seek treatment for eating disorders. *International Journal of Eating Disorders.25, pp.415-424.*

Bruch,H. (1973). *Eating Disorders*. Basic Books. New York.

Bulik,C.M., Sullivan,P.F., & Kendler,K.S. (2003). Genetic and environmental contributions to obesity and binge eating. *International Journal of Eating Disorders, 33, 3, pp. 293–298.*

Cafri,G., van den Berg,P., Thompson,K.,J. (2006). Pursuit of muscularity in adolescent boys: relations among bio-psychosocial variables and clinical Outcomes. *Journal of Clinical Child & Adolescent Psychology,Vol,35,2 pp. 283-291.*

Callam, R.,Waller, G.,Slade,P., & Newton, T.(1990). Eating disorders and perceived parental relationships with parents. *International Journal of Eating Disorders*,9, 5, pp. 479–485.

Carlat,D.J., Carmago,C.A. (1991). Review of Bulimia Nervosa in Males. *American Journal of Psychiatry,148,pp.831-843.*

Carlat,D.J., Carmago,C.A. (1997). Eating disorders in males: a report on 135 patients. *American Journal of Psychiatry. 154,pp. 1127-1132.*

Carlson Jones, D.,Crawford,J.K. (2005). Adolescent Boys and Body Image: Weight and Muscularity Concerns as Dual Pathways to Body Dissatisfaction. *Journal of Youth & Adolescence, Vol.34,6, pp.629-636.*

Cash,T.F.,(2004). 'Body image: Past, present and future,' *Body Image: An International Journal of Research*, *1, pp. 1–5.*

Cash, T. F. (2000). *Manual for the Multidimensional Body-Self Relations Questionnaire*. Body Image Assessments.

Cash,T.F., & Labarge, A.S. (1996). Development of the Appearance Schemas Inventory: A new cognitive body-image assessment*. Cognitive Therapy and Research, 20 ,1, pp 37-50.*

Cash, T. F. (1994b).*The Multidimensional Body-Self Relations Questionnaire users' manual*. Available from the author, Old Dominion University, Norfolk, VA.

Cervera, S., Lahortiga, F., Martinez-Gonzalez, M. A., Gual, P., de Irala-Estevez, J., & Alonso, Y. (2003). Neuroticism and low self-esteem as risk factors for incident eating disorders in a prospective cohort study. *International Journal of Eating Disorders, 33, pp.271-280*.

Cillessen, A. H. N., & Mayeux, L. (2004). Sociometric status and peer group behavior: Previous findings and current directions. In J. B. Kupersmidt & K. A. Dodge (Eds.), *Children's peer relations: From development to intervention.* Washington, DC: American Psychological Association Press.

Clement, U., & Lowe, B.(1996). Validation of the FKB-20 as scale for the detection of body image distortions in psychosomatic patients. *Psychtherapie Psychosomatik Medizinische Psychologie, 46,7, pp.254-259*.

Cogan,J.C., Bhalla, S.K., Sefa-Dedeh,A., & Rothblum,E.D. (1996). A comparison study of United States and African Students on Perceptions of Obesity and Thinness. *Journal of Cross Cultural Psychology. 27, 1, pp.98-113.*

Cohane,G.H.,Pope,Jr,H.G.(2001). Body image in boys a review of the literature. *International Journal of Eating Disorders. Vol.29, 4, pp.373-379.*

Cole, T. J., Bellizzi, M. C., Flegal, K. M., & Dietz, W. H. (2000). Establishing a standard definition for child overweight and obesity worldwide: International survey. *British Medical Journal, 320, pp.1240−1245.*

Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairburn, C. G. (1987). The development and validation of the Body Shape Questionnaire. *International Journal of Eating Disorders, 6, (4), pp. 485-494.*

Crisp, A.H. T. Burns, Y. & A.V. Bhat, A.V. (1986). Primary anorexia nervosa in the male and female. *British Journal of Medical Psychology, 59, pp. 123–132.*

Croll, J., Neumark-Sztainer, D., Story, M., & Ireland, M. (2002). Prevalence, risk and protective factors related to disordered eating behaviours among adolescents: relationship to gender and ethnicity. *Journal of Adolescent Health, 31, pp.166-175.*

Dallesasse, S., Carney, J., Dagley, J., Kluck, A. (2011). *Reality Television and the Muscular Ideal*. (Doctoral Dissertation). Available from Auburn Theses and dissertations. (UMI: 10415/2481).

Derogatis, L. (1977). *SCL-90-R. Administration, scoring and procedures Manual 1 for revised version of the SCL-90.* Baltimore: John Hopkins University Press.

Deusinger, I. M. (1998). The Frankfurter Body Concept Scales: Manual with validation studies. *Göttingen: Hogrefe.*

Donnerstein, E., & Smith, S. (2001). Sex in the media: Theory, influences, and solutions. In D. Singer & J. Singer (Eds.), *Handbook of children and the media* (pp. 289-307). Thousand Oaks, CA: Sage Publications.

Durham, M. (1998). Dilemmas of desire: Representations of adolescent sexuality in two teen magazines. *Youth and Society,* 29,(3), 369-389.

Eiben, G. (2007). *Overweight and obesity in the young and old: Prevalence, prevention, and eating behaviour.* Unpublished doctoral thesis, Go¨teborg University, Go¨teborg, Sweden.

Eisenberg, M.E., Neumark-Sztainer,D., & Paxton,S.J.(2006). Five-year change in body satisfaction among adolescents. *Journal of Psychosomatic Research, 61, pp. 521–527.*

* Eisenberg, M.E, & Neumark-Sztainer, D. (2010). Friends' dieting and disordered eating behaviours among adolescents five years later: Findings from Project EAT. *Journal of Adolescent Health.47,(1), pp. 67-73.*

Eme, R. F., & Danielak, M. H. (1995). Comparison of fathers of daughters with and without maladaptive eating attitudes. *Journal of Emotional Behaviour Disorders. 3, pp. 40–45.*

Fairburn, C.G., & Beglin, S. J. (1990). Studies of the epidemiology of bulimia nervosa. *The American Journal of Psychiatry. 147,(4), pp. 401-408*.

Fairburn, C.G., & Beglin, S.J. (1994). Assessment of eating disorders: Interview or self-report questionnaire? *International Journal of Eating Disorders. 16, 4, pp. 363–370.*

Fairburn, C.G., Doll, H.A., Welch, S.L., Hay, P.J., Davies, B.A., & O'Connor, M.E. (1998). Risk factors for binge eating disorder: A community-based, case-control study. *Archives of General Psychiatry, 55,5, pp. 425–432*.

Fairburn, C.G., Welch, S.L., Doll, H.A., Davies, B.A., & O'Connor, M.E. (1997). Risk factors for bulimia nervosa. A community-based case-control study. *Archives of General Psychiatry*,*54,6, pp. 509–517*.

Fernández-Aranda, F., Krug, I., Granero, R., Ramón, J.M., Giménez, L., Solano, R., Collier, D., Karwautz, A., & Treasure, J. (2007). Individual and family eating patterns during childhood and early adolescence: An analysis of associated eating disorder factors. *Appetite, 49, pp.476–485.*

Field, A.E., Austin, B,S., Camargo, Jr, C.A., Taylor, B.C., Striegel-Moore, R.H., Loud, K.J., & Colditz, G.A. (2005). Exposure to the Mass Media, Body Shape Concerns, and Use of Supplements to Improve Weight and Shape Among Male and Female Adolescents. *Pediatrics,116, 2, pp. 214-220.*

Furman, W., & Shomaker, L.B. (2009). Patterns of interaction in adolescent romantic relationships: Distinct features and links to other close relationships. *Journal of Adolescence, 31,(6), pp.771-778.*

Games, Paul A. (1990). Correlation and causation: A logical snafu. *Journal of Experimental Education*,*58,(3), pp.239-246*.

Garfinkel, P. E., Lin, E., Goering, P., Spegg, C., Goldbloom, D.S., & Kennedy, S. (1995). Bulimia nervosa in a Canadian community sample: prevalence and comparison of subgroups. *American Journal of Psychiatry*, *152, pp.1052-58.*

Garner, D.M., Olmstead, M.P., Bohr, Y., & Garfinkel, P.E. (1982). The Eating Attitudes Test: psychometric features and clinical correlates. *Psychological Medicine, 12, pp. 871-878.*

Garner, D.M., Olmstead, M.P., & Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders, 2, pp.15–34.*

Garner, D.M. (1984). *The Eating Disorder Inventory Manual.* Assessment Resources Inc.

Garner, D. M. (2004). *Eating Disorder Inventory-3 professional manual*. Lutz, FL: Psychological Assessment Resources, Inc.

Ghaderi, A., Scott, B. (2001). Prevalence, incidence and prospective risk factors for eating disorders. *Actica Psyhciatrica Scandinavica. 104, 2, pp. 122-130.*

Goldberg, D. P., & Blackwell, B. (1970). Psychiatric illness in general practice: A detailed study using a new method of case identification. *British Medical Journal, 1, pp.439-443.*

Goldberg, D., & Williams, P. (1988). *A user's guide to the General Health Questionnaire*. Windsor, UK: NFER-Nelson.

Gralen, S. J., Levine, M. P., Smolak, L., & Murnen, S. K. (1990). Dieting and disordered eating during early and middle adolescence: Do the influences remain the same? *International Journal of Eating Disorders, 9, pp.501-512.*

Groesz, L. M., Levine, M. P., & Murnen, S. K. (2002). The effect of experimental presentation of thin media images on body satisfaction: A meta-analytic review. *International Journal of Eating Disorders, 31, pp.1–16.*

Grogan, S.(2008). *Body image: Understanding body dissatisfaction in men, women, and children*. Routledge, London.

Halliwell, E., & Dittmar, H. (2003). A qualitative investigation of women's and men's body image concerns and their attitudes towards aging. *Sex Roles,49, pp. 675–684*.

* Hargreaves, D, A., & Tiggemann, M. (2004). Idealized media images and adolescent body image: ‘‘comparing’’ boys and girls. *Body Image, 1, pp.351–361.*

Hargreaves,D.,Tiggemann, M. (2002). The Effect of “Thin Ideal” Television Commercials on Body Dissatisfaction and Schema Activation During Early Adolescence. *Journal of Youth and Adolescence,32,5, pp.367-373.*

Hargreaves, D. A., and Tiggemann, M. (2002). The effect of television commercials on mood and body dissatisfaction: The role of appearance-schema activation. *Journal of Social Clinical Psychology. 21,pp. 328–349.*

Haselhuhn, G., Thompson, J. K., Roehrig, M., Shroff, H., van den Berg, P., & Keery, H. (2001). Development of the Media Influence Scale for Adolescent Boys (MISAB). *Paper presented at the annual meeting of the Association for the Advancement of Behaviour Therapy, Philadelphia.*

Hayley, C., Hedburg, K., & Leman, R. (2010). Disordered eating and unhealthy weight loss practices; which adolescents are at highest risk. *Journal of Adolescent Health,47, (1), pp. 102-105.*

Heinberg, L.J., Thompson, K,J., & Stormer, S. (1995). Development and validation of the socio-cultural attitudes towards appearance questionnaire. *International Journal of Eating Disorders, 17, (1),pp.81-89.*

Heinberg, L. J., & Thompson, J. K. (1995). Body image and televised images of thinness and attractiveness: A controlled laboratory investigation. *Journal of Social and Clinical Psychology,14, pp.325–338.*

Herdt, G. (1987). *Sambia: Ritual and gender in New Guinea*. New York:

Horesh, N., Apter, A., Ishai, J., Danzinger, Y., Miculincer, M., Stein, D., Lepkifker, E., & Minouni, M.(1996). Abnormal psychosocial situations and eating disorders in adolescence. *American Academia Child Adolescent Psychiatry, 35, pp.921–927.*

Hsu.,L.K.K.,(1996). Epidemiology of the eating disorders. *Psychiatry Clinical North America*, *19, pp. 681–700.*

Hudson,J.I., Hiripi,E., Pope Jr, G., Kessler, R.C (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*, *61,(3), pp.348-358.*

Hudson,W,W. (1982). A measurement package for clinical workers. *Journal of Applied Behavioral Science,18,(2), pp. 229-238.*

Hudson,W.W. (1982). *The Clinical Measurement Package: A Field Manual*. The Dorsey Press, Illinois.

Hutchinson, D., & Rapee, R. (2006). Do friends share similar body image and eating problems? The role of social networks and peer influences in early adolescence. *Behaviour Research and Therapy*, *45, (7), pp. 1557-1577.*

Iannotti, R.J., & Bush, P.J. (1993). Perceived vs. actual friends' use of alcohol, cigarettes marijuana, and cocaine: Which has the most influence? *Journal of Youth Adolescence, 21, 3, pp. 375–89.*

Jafar,T.H., Qadri,Z.. Islam, M.,Hatcher,J.,Bhutta,Z.A., Chaturvedi,N.(2008). Rise in childhood obesity with persistently high rates of under-nutrition among urban school-aged Indo-Asian children. *Archives of Diseases in Childhood.93,pp. 373-378.*

Jessor R. (1982). Problem behaviour and developmental transition in adolescence. *Journal of School Health, 52,(5), pp.295–300.*

Jones,C.A., Crawford,J.K. (2005). Adolescent boys and body image: Weight and muscularity concerns as dual pathways to body dissatisfaction. *Journal of Youth and Adolescence,34, 6, pp.629-636.*

Kaltiala-Heino, R., Rimpel, M., Rissanen, A., & Rantanen,P. (2001). Early puberty and early sexual activity are associated with bulimic-type eating pathology in middle adolescence. *Journal of Adolescent Health*,*28, pp.346-352*.

Katzman,M.A., Wolchik,S. A., Braver, S. L. (1984). The prevalence of frequent binge eating and bulimia in a nonclinical college sample. *International Journal of Eating Disorders, Vol 3,(3), pp.53-62.*

Keel, P., Fulkerson,J.A., & Leon,G,R. (1997). Disordered eating precursors in early adolescent girls and boys. *Journal of Youth and Adolescence, 26,(2),pp.203-216.*

Keery, H., van den Berg, P., & Thompson, J. K. (2004). An evaluation of the tripartite influence model of body dissatisfaction and eating disturbance with

adolescent girls. *Body Image: A Journal of International Research, 1, pp.237–251.*

Kendler, K. S., MacLean, C., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1991). The genetic epidemiology of bulimia. *American Journal of Psychiatry, 148, pp.1627–1637.*

Kendler, K. S., Walters, E. E., Neale, M. C., Kessler, R. C., Heath, A. C., & Eaves, L. J. (1995). The structure of the genetic and environmental risk factors for six major psychiatric disorders in women. *Archives of General Psychiatry, 52, pp.374–383.*

Keski-Rahkonen,A.,Kaprio,J.,Rissanen,A., Virkkunen, M., & Rose,R.J.(2003). Breakfast skipping and health-compromising behaviours in adolescents and adults. *European Journal of Clinical Nutrition, 57,7,pp. 842–853.*

Killen, J. D., Hayward, C, Litt., L., Hammer, L. D., Wilson, D. M., Miner, B., Taylor, C. B.,Varady, A., & Shisslak, C. (1992). Is puberty a risk factor for eating disorders? *American Journal of Diseases in Children, 146, pp.323-325.*

Killen, J. D., Hayward, C., Wilson, D. M., Taylor, C. B., Hammer, L. D., Litt, L., Simmonds,B., & Haydel, F. (1994). Factors associated with eating disorder symptoms in a community sample of 6th and 7th grade girls. *International Journal of Eating Disorders, 15, pp.357-367.*

Klump, K. L., Miller, K. B., Keel, P. K., McGue, M., & Iacono, W. G. (2001). Genetic and environmental influences on anorexia nervosa syndromes in a population-based twin sample. *Psychological Medicine, 31, pp.737–740.*

* Knauss, C., Paxton, S.J., & Alsaker, F.D. (2007). Relationships amongst body dissatisfaction, internalisation of the media body ideal and perceived pressure from media in adolescent girls and boys. *Body Image, 4, pp. 353–360.*

Koff, E., & Rierdan, J. (1993). Advanced pubertal development and eating disturbance in early adolescent girls. *Adolescent Health,14, pp.433-439.*

Kortegaard, L.S., Hoerder, K., Joergensen, J., Gillberg, C., & Kyvik, K.O. (2001). Preliminary population-based twin study of self-reported eating disorder. *Psychological Medicine, 31, 2, pp. 361–365.*

Kovacs, M. (1981). Rating scales to assess depression in school-aged children.

Acta Paedopsychiatrica: International Journal of Child & Adolescent Psychiatry, 46, 5-6, pp. 305-315.

Kovacs, M., Betof, N. G., Celebre, J. E., Mansheim, P. A., Petty, L. K., & Raynak, J. T. (1977). *Childhood depression: Myth of clinical syndrome?* Unpublished manuscript. University of Pennsylvania, Philadelphia.

Lamb, C. S., Jackson, L. A., Cassiday, P. B., & Priest, D. J. (1993).Body figure preferences of men and women: A comparison of two generations. *Sex Roles, 28, 345–357.*

Langley, J.(2006). *Boys get anorexia too: Coping with male eating disorders in the family*. London, England: Paul Chapman Publishing.

Larson, R. (1995). Secrets in the bedroom: Adolescents' private use of media. *Journal of Youth and Adolescence, 24,(5), pp.* 535-550.

Latner, J.D., & Stunkard, A.J (2003). Getting Worse: The Stigmatization of Obese Children. *Obesity Research, 11, pp.452–456.*

Lattimore, P.J., & Halford, J.C.(2003). Adolescence and the diet–dieting disparity: Healthy food choice or risky health behaviour? *British Journal of Health Psychology, 8, 4, pp. 451–463.*

Leon, G. R., Carroll, K., Chernyk, B., & Finn, S. (1985). Binge eating and associated habit patterns within college student and identified bulimic populations. *International Journal of Eating Disorders, 4, pp.43-57.*

Leon, G. R., Fulkerson, J. A., Perry, C. L., & Cudeck, R. (1993). Personality and behavioural vulnerabilities associated with risk status for eating disorders in adolescent girls. *Journal of Abnormal Psychology, 102, pp.438-444*.

Leon, G. R., Fulkerson, J. F., Perry, C. L., & Early-Zald, M.(1995). Prospective analysis of personality and behavioral vulnerabilities and gender influences in the later development of disordered eating. *Journal of Abnormal Psychology, 104, pp.140-149.*

Lerner, R. M., Karabenick, S. A., & Stuart, J. L. (1973). Relations among physical attractiveness, body attitudes, and self-concept in male and female college students. *Journal of Psychology, 85, pp.119-129.*

Levine, M. P., Smolak, L., & Hayden, H. (1994). The relation of socio-cultural factors to eating attitudes and behaviors among middle school girls. *Journal of Early Adolescence, 14, pp.471–490.*

Levine, M. P., & Smolak, L. (2001). Primary prevention of body image disturbances and disordered eating in childhood and early adolescence. In J. K. Thompson & L. Smolak (Eds.), *Body image, eating disorders, and obesity in youth: Assessment, prevention, and treatment* (pp. 237–260). Washington, DC: American Psychological Association.

Levine, M. P., & Smolak, L. (2005). *Prevention of eating problems and eating disorders: Theory, research, and practice.* Mahwah, NJ: Erlbaum.

Lewinsohn,P.M. Seeley,J.R., Moerk, K.C. Streigel-Moore,R.H. (2002). Gender differences in eating disorder symptoms in young adults. *International Journal of Eating Disorders.Vol.32,(4),p426-440.*

Llewellyn-Jones, D. (1997). *Fundamentals of obstetrics and gynaecology* (6th ed.).London:Mosby.

Lovibond,P.F., & Lovibond,S.H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33, 3, pp. 335-343.*

Malamuth, N., & Impett, E. (2001). Research on sex in the media: What do we know about effects on children and adolescents? In D. Singer & J. Singer (Eds.), *Handbook of children and the media* (pp. 289-307). Thousand Oaks, CA: Sage Publications.

Marsh H. (1988). *Self-Description Questionnaire manual: a theoretical and empirical basis for measuring multiple dimensions of late adolescent self-concept: A test manual and research monograph.* San Antonio, Texas: The Psychological Corporation.

Mazzeo, S. E., Mitchell, K. S., Bulik, C. M., Reichborin-Kjennerud, T., Kendler, K. S., & Neale, M. C. (2008). Assessing the heritability of anorexia nervosa symptoms using a marginal maximal likelihood approach. *Psychological Medicine, 19, pp.1–11*.

* McCabe' ,M.P., Ricciardelli, L.A., & Banfield, S. (2001). Body image, strategies to change muscles and weight, and puberty: Do they impact on positive and

negative affect among adolescent boys and girls? *Eating Behaviours, 2, 2, pp.129-149.*

* McCabe, M.P., Ricciardelli, L.A., & Finemore, J. (2002). The role of puberty, media and popularity with peers on strategies to increase weight, decrease weight and increase muscle tone among adolescent boys and girls. *Journal of Psychosomatic Research, 52, pp. 145–153.*

McCabe, M.P., & Ricciardelli, L.A. (2001). The structure of the Perceived Socio-cultural Influences on Body Image and Body Change Questionnaire. *International Journal of Behavioral Medicine, 8, pp. 19–41.*

McCabe, M.P., & Ricciardelli, L. A. (2004). Body image dissatisfaction among males across the lifespan: A review of past literature. *Journal of Psychosomatic Research, 56,6, pp. 675-685.*

* McCabe, M.P., Ricciardelli, L.A, & Finemore, J.(2003). A biopsychosocial model for understanding body image and body change strategies among children. *Journal of Applied Developmental Psychology, 24, 4, pp. 475-495.*

McCabe, M.P., & Ricciardelli, L .A. (2005). A longitudinal study of body image and strategies to lose weight and increase muscles among children. *Journal of Applied Developmental Psychology, 26, (5*), *pp. 559-577*.

McCabe, M.P., & Ricciardelli, L.A. (2006). A prospective study of extreme weight change behaviours among adolescent boys and girls. *Journal of Youth and Adolescence,* 35, *pp. 425–434*.

* McCabe, M.P., Ricciardelli, L.A. & Holt, K.(2010). Are there different socio-cultural influences on body image and body change strategies for overweight adolescent boys and girls? *Eating Behaviours,11, (3), pp 156-163.*

McCreary, D.R. (2007). The Drive for Muscularity Scale: Description, Psychometrics, and Research Findings. The muscular ideal: Psychological, social, and medical perspectives. In K.J., Thompson, (Ed) & G., Cafri, (Eds), (2007). *The muscular ideal: Psychological, social, and medical perspectives,* (pp. 87-106). Washington, DC, US: American Psychological Association.

Minuchin, S., Rosman, B. L., & Baker, L. (1978). *Psychosomatic Families: Anorexia in Context*. Cambridge, MA, Harvard University Press.

Neumark-Sztainer, D., Falkner, N., Story, M., Hannan, P.J., & Mulert, S. (2002). Weight-teasing among adolescents: Correlations with weight status and disordered eating behaviours. *International Journal of Obesity, 26, pp. 123–131.*

Nottelman E.D., Susman E.J., & Inoff-Germain, G. (1987). Developmental processes in early adolescence: Relationships between adolescent adjustment problems and chronologic age, pubertal stage, and puberty-related serum hormone levels. *Journal of Pediatrics,110, pp.473–80.*

Oates-Johnson, T., & DeCourville, N. (1999). Weight preoccupation, personality, and depression in university students: An interactionist perspective. *Journal of Clinical Psychology, 55,(9), pp. 1157-1166.*

O'Dea, J.A., & Abraham, S. (1999). Onset of disordered eating attitudes and behaviours in early adolescence: interplay of puberty status, gender weight and age. *Adolescence, 34,(136),pp. 671-679.*

Ogden, C. L., Carroll, M. D., & Flegal, K. M. (2008). High body mass index for age among US children and adolescents 2003–2006. *Journal of the American Medical Association, 299, pp. 2401–2405.*

Olsen, D. H. (1991). Commentary: Three-dimensional (3-D) circumplex model and revised scoring of Faces III. *Family Process, 30, pp. 74-79.*

Parker, G., Tupling, H., and Brown, L. B. (1979). A parental bonding instrument. *British.Medical Psychology,52,pp. 1–10.*

Pearce, M. J., Boergers, J., & Prinstein, M. J. (2002). Adolescent obesity, overt and relational peer victimisation, and romantic relationships. *Obesity Research,10, pp.386–393.*

Petersen, A.C., & Crockett, L. (1985). Pubertal timing and grade effects on adjustment. *Journal of Youth and Adolescence,14, (3), pp.191-206.*

Petersen, A.C., Crockett, L., Richards, M., & Boxer, A.M. (1988). Measuring pubertal status; Reliability and validity studies. *Journal of Youth and Adolescence, 17, (2), pp. 117-133.*

Petersen, A., Schulenberg, J., Abramowitz, R., Offer, D., & Jarcho, H. (1984). A Self-Image Questionnaire for Young Adolescents (SIQYA): Reliability and validity studies. *Journal of Youth and Adolescence,13, 93–111.*

Pinheiro, A.P., Root, T., & Bulik, C.M.(2009). The genetics of anorexia nervosa: Current findings and future perspectives. *International Journal of Child and Adolescent Health, 2, (2), pp.153-163.*

Phillips, K.A, Castle,D. (2001). Body dysmorphic disorder in men. *British Medical Journal, 3, 323(7320): pp. 1015–1016.*

Polivy, J., Herman, C. P., & Howard, K. I. (1988). Restraint Scale: Assessment of dieting. In, M. Hersen, & A.S. Bellack (Eds.), *Dictionary of Behavioural Assessment Techniques. Pergamon Press, Elmsford, NY.*

Pope, H. G., Phillips, K. A., & Olivardia, R. (2000). The Adonis complex: The secret crisis of male body obsession. *New York: Free Press.*

Pope, H. G., Olivardia, R., Gruber, A., & Borowiecki, J. (1999). Evolving ideals of male body image as seen through action toys. *International Journal of Eating Disorders, 26, pp.65–72.*

Prinstein, M.J., & Wang, S.S.(2005). False consensus and adolescent peer contagion: Examining discrepancies between perceptions and actual reported

levels of friends' deviant and health risk behaviours. *Journal of Abnormal Child Psychology, 33, (3), pp. 293–306.*

Radloff, L. (1977). A CES–D Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1, pp.385–401.*

Rahkonen, O., Suoknuutti, R., & Teperi J. (1985). The reliability of some variables in a follow-up study. Terveyskasvatustutkimuksenvuosikirja: The Yearbook of the Health Education Research (in Finnish, English summary). *The National Board of Health, Finland.*

*Rancourt, D., & Prinstein, M.J. (2010). Peer Status and Victimisation as Possible Reinforcements of Adolescent Girls and Boys' Weight-Related behaviours and Cognitions. *Journal of Paediatric Psychology, 35, (4), pp.354-367.*

Rastam, M., Gillberg, C., & Garton, M. (1989). Anorexia Nervosa in a Swedish urban region. A population based study. *The British Journal of Psychiatry, 155, pp.642-646.*

Raudenbush, B., & Zellner, D. A. (1997). Nobody's satisfied: Effects of abnormal eating behaviours and actual and perceived weight status on body image

satisfaction in males and females. *Journal of Social and Clinical Psychology, 16, pp.95–110*.

Ricciardelli,L.A.,McCabe,M.P.(2011). Body image development in adolescent boys. In Body image: *A handbook of science, practice, and prevention* (2nd ed.), edited by Cash, Thomas F., Smolak, Linda, pp. 85-92. New York, NY, US:Guilford Press*.*

Ricciardelli,L,A.,McCabe,M,P.,Mussap,A,J. Holt,K,E. (2009). In *Body image, eating disorders, and obesity in youth: Assessment, prevention, and treatment. (2nd ed)*, edited by Smolak, Linda, Thompson, J. Kevin, 77-96. Washington, DC, US:American Psychological Association, 2009.

Ricciardelli, L.A., & McCabe, M.P. (2003a). A longitudinal analysis of the role of biopsychosocial factors in predicting body change strategies among adolescent boys. *Sex Roles, 48, pp.349–359.*

Ricciardelli, L.A., & McCabe, M.P. (2002). Psychometric evaluation of the Body Change Inventory: An assessment instrument for adolescent boys and girls, *Eating Behaviours, 3, (1), pp. 45–59.*

Ricciardelli, L.A., & McCabe, M.P. (2001a). The structure of the perceived socio-cultural influences on body image and body change questionnaire*, International Journal of Behavioural Medicine*, *8, (1), pp. 19-41.*

Richards, M.H., Boxer, A.M., Petersen, A.C., & Albrecht, R. (1990). Relation of weight to body image in pubertal girls and boys from two communities. *Developmental Psychology, 26, pp.313-321.*

Richards,M.H., Casper,R.C., Larson,R. (1990). Weight and eating concerns among pre- and young adolescent boys and girls. *Journal of Adolescent Healthcare, Vol.11,3,pp.203-209.*

Rosen, J.C., & Gross, J. (1987). Prevalence of weight reducing and weight gaining in adolescent girls and boys. *Health Psychology,6, pp.131-147.*

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, NJ: Princeton University Press.

Saha, A.K., Sarkar, N., Chatterjee, T. (2011). Health Consequences of Childhood Obesity. *Indian Journal of Peadiatrics, 78,11, pp.1349-1355.*

Schutz, H., Paxton, S., & Wertheim, E. (2002). Investigation of body comparison among adolescent girls. *Journal of Applied Social Psychology, 32,pp.*1906–1937.

Sepulveda, A., Carrobles, J.A., & Ganarillas, A.,M. (2010). Associated factors of unhealthy eating patterns among Spanish university students by gender. *Spanish Journal of Psychology, 13, (1), pp.364-375*.

Shisslak, C.M., Shisslak, R.E.D., Ranger, T., Sharp, M., Crago, K.M., & McKnight Gray, N. (1999). Development and evaluation of the McKnight Risk Factor Survey for assessing potential risk and protective factors for disordered eating in preadolescent and adolescent girls. *International Journal of Eating Disorders, 25, (2), pp. 195–214.*

* Smolak, L., Murmen, S., & Thompson, J.K.(2005). Socio-cultural influences and muscle building in adolescent boys. *Psychology of Men Masculinity, 6, pp.227-239.*

Snelgrove, R., & Havitz, M. E. (2010). Looking Back in Time: The pitfalls and potential of retrospective methods in leisure studies. *Leisure Sciences, 32, pp.337-351.*

Sonstroem, R.J., & Potts, S.A. (1996). Life adjustment correlates of physical self-concepts. *Medicine and Science in Sports and Exercise, 28, pp. 619–625.*

Spielberger,C.,Gorsuch,R., & Lushene,R.(1970). *Manual for the State Trait Anxiety Inventory.* Palo Alto; Consulting Psychologists Press.

*Stanford, J., & McCabe, M.P. (2005). Socio-cultural influences on adolescent boys' body image and body change strategies. *Body Image, 2, pp.105–113.*

Stattin, H., & Magnusson, D.(1990). *Paths Through Life, Vol. 2: Pubertal Maturation in Female Development.* Hillsdale, NJ: Erlbaum Associates.

Steele, J. R. (1999). Teeange sexuality and media practice: Factoring in the influences of family, friends, and school. *Journal of Sex Research,36,(4), pp.331-341.*

Steinfeldt,J.A., Carter,H., Benton,E., Steinfeldt, M.C. (2011). Muscularity beliefs of female college student-athletes. *Sex Roles,64, 7-8,pp 543-554.*

Stephens, D.L., Hill, R.P., & Hansen, C.(1994). The beauty myth and female consumers. The controversial role of advertising. *The Journal of Consumer Affairs, 28, pp. 137-153.*

Stewart, A. W., Jackson, R. T., Ford, M. A., & Beaglehole, R. (1987). Under-estimation of relative weight by use of self-reported height and weight. *American Journal of Epidemiology, 125,1, pp.122-6.*

Stice, E., Spangler, D., & Agras, W. S. (2001). Exposure to media portrayed thin-ideal images adversely affects vulnerable girls: A longitudinal experiment. *Journal of Social and Clinical Psychology, 20, pp.270–288.*

Strahan,E.J., Wilson,A.E., Cressman,K.E., & Buote,V.M.(2006). Comparing to perfection: How cultural norms for appearance affect social comparisons and self-image, *Body Image, 3, pp. 211–227*.

Striegel-Moore,R.H., Franko, D.L., Thompspn,D., Barton,B., Schrieber,G.B., & Daniels, S.R. (2005). An empirical study of the typology of bulimia nervosa and its spectrum variants. *Psychological Medicine, 35, pp.1563-1572.*

Striegel-Moore, R. H., & Kearney-Cooke, A. (1994). Exploring parents' attitudes and behaviors about their children's physical body. *International Journal of Eating Disorders, 15,pp. 377–385.*

Striegel-Moore,R.H., Garvin,V., Dohm,F.A.,Rosenheck,R.A (1999). Psychiatric comorbidity of eating disorders in men. *International Journal of Eating Disorders*, 25, pp. 399–404.

Strober, M., Freeman, R., Lampert, C., Diamond, J., & Kaye, W. (2001). Males with anorexia nervosa: a controlled study of eating disorders in first-degree relatives. *International Journal of Eating Disorders, 29,(3), pp.263–9.*

Strober, M., Humphrey, L. L.(1987). Familial contributions to the etiology and course of anorexia nervosa and bulimia. *Journal of Consulting and Clinical Psychology, 55,(5), 654-659.*

Strober, M., Freeman,R., Morrell,W. (1997). The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10–15 years in a prospective study. *International Journal of Eating Disorders, 22, (4), pp.339-360.*

Strouse, J. S., & Buerkel-Rothfuss, N. (1987). Media exposure and sexual attitudes and the behaviours of college students. *Journal of Sex Education and Therapy, 13,2,pp.43-51.*

Swarr, A. E., & Richards, M. H. (1996). Longitudinal effects of adolescent girls' pubertal development, perceptions of pubertal timing and parental relations on eating problems. *Developmental Psychology, 32, pp. 636–646.*

Thelen,M.H., & Cormier,J. (1995). Desire to be thinner and weight control among children and their parents. *Behavior Therapy, 26, (1), pp. 85–99.*

Thelen, M.H., Mintz, L.B.,Vander Wal,J.S.(1991). The Bulimia Test-Revised: Validation with DSM-IV criteria for bulimia nervosa. *Psychological Assessment, 8, 2, pp. 219-221.*

Thelen, M.H., Farmer,J., Wonderlich, S. Smith, M. (1991). A revision of the Bulimia Test: The BULIT—R. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 3,(1), pp. 119-124.*

Thogersen-Ntoumani, C., Ntoumanis, N., & Nikitaras, N. (2010). Unhealthy weight control behaviours in adolescent girls: a process model based on self-determination theory. *Psychology & Health, 25, (5), pp.535-550.*

Thompson, K.J., Coovert, Richards, K.J., Johnson, S., & Cattarin, J. (1995). Development of body image, eating disturbance, and general psychological functioning in female adolescents: covariance structure modelling and longitudinal investigations. *International Journal of Eating Disorders,18, pp.221–236.*

Thompson, J. K., Cattarin, J., Fowler, B., & Fisher, E. (1995). The Perception of Teasing Scale (POTS): A revision and extension of the Physical Appearance Related Teasing Scale (PARTS). *Journal of Personality Assessment, 65, pp.146–157.*

Thompson, J. K., Heinberg, L. J., & Tantleff, S. T. (1991). The Physical Appearance Comparison Scale (PACS). *The Behaviour Therapist, 14, pp.174-178.*

Thompson, J.K., van den Berg, P., Roehrig,M., Guarda, A. S., & Heinberg, L. J., (2004). The Socio-cultural Attitudes Towards Appearance Scale-3 (SATAQ-3):

Development and Validation. *International Journal of Eating Disorders, 35, (3), pp. 293-304.*

Thompson, J.K., Coovert, M.D., Richards, K.J., Johnson, S., & Callarin, J., (1995). Development of body image, eating disturbance, and general psychological functioning in female adolescents: covariance structure modelling and longitudinal investigations. *International Journal of Eating Disorders, 18, pp. 221–236.*

Thompson, J.K., Heinberg, L.J., Altabe, M., & Tantleff-Dunn, S. (1999). *Exacting beauty: Theory, assessment, and treatment of body image disturbance*. American Psychological Association, Washington, DC.

Tiggemann, M., & McGill, B. (2004). The role of social comparison in the effect of magazine advertisements on women's mood and body dissatisfaction. *Journal of Social and Clinical Psychology, 23, pp. 23–44.*

Tiggemann, M., & Pickering, A.S.(1996). Role of television in adolescent women's body dissatisfaction and drive for thinness. *International Journal of Eating Disorders, 20, (2), pp.199-203.*

Toscano,K.T.(2011). *The effect of media on body image as mediated by gender*. Kean University, 40 pages, 1495138. Unpublished thesis.

Tremblay,L., & Lariviere, M. (2009). The influence of puberty onset, Body Mass Index, and pressure to be thin on disordered eating behaviors in children and adolescents. *Eating Behaviours,10,2.pp.75-83.*

Troiano, R.P., & Flegal, K.M.(1988). Overweight children and adolescents: description, epidemiology, and demographics. *Paediatrics, 101, 3, pp.497-504.*

Van den Berg, P., Thompson, J. K., Obremski-Brandon, K., & Coovert, M. (2002). The Tripartite Influence model of body image and eating disturbance A covariance structure modelling investigation testing the mediational role of appearance comparison. *Journal of Psychosomatic Research, 53, pp.1007–1020.*

Van Strien,T., Frijters,J.E.R., Bergers,G.P.A., & Defares,P,B. (1986). The Dutch Eating Behavior Questionnaire (DEBQ) for assessment of restrained, emotional, and external eating behaviour. *International Journal of Eating Disorders, 5, 2, pp. 295-315.*

Varni, J.W., Seid, M., & Kurtin, P.(2001). The Peds Q 4.0: Reliability and validity of the Pediatric Quality of Life Inventory, Version 4.0 generic core scales in healthy and patient populations. *Medical Care, 39, pp. 800-812.*

Videon,T.M. & Manning,C.K. (2003). Influences on adolescent eating patterns: the importance of family meals. *Journal of Adolescent Health, 32,5,pp.365-373.*

*Vincent, M. A., & McCabe, M. P. (2000). Gender differences among adolescents in family and peer influences on body dissatisfaction, weight loss and binge eating behaviours. *Journal of Youth and Adolescence, 29, pp. 205–221.*

Wade, T. D., Bulik, C. M., & Kendler, K. S. (2000). Anorexia nervosa and major depression: An examination of shared genetic and environmental risk factors. *American Journal of Psychiatry, 157, pp.469–471.*

Ward, A., Ramsay,R., & Treasure,J. (2000). Attachment research in eating disorders. *British Journal of Medical Psychology, 73, pp. 35–51.*

Watson, D., Clark, L.A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales, *Journal of Personality and Social Psychology, 54, (6), pp. 1063–1070.*

Weber,C.C., Haller,D.M., & Narring,F.(2010). Is there a role for primary care physicians' screening of excessive weight and eating concerns in adolescence? *Journal of Paediatrics, 157, (1), pp.32-35.*

Wellings, K., & Field, B. (1996). Sexual behaviour in young people. *Bailliere Clin Obstet Gynaekol ,10, pp.139–60.*

Wilson, R. J. (1990). *Are the times a'changin'? A content analysis of Rolling Stone Magazine, 1968 and 1988.* Unpublished master's project, Georgia State University, Atlanta, Georgia

Chapter Two

Therapists' experiences of working with men with eating disorders

Paper prepared for submission to the European Eating Disorder Review

(See appendix A for notes to contributors)

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2.1 Abstract

Despite statistics suggesting that there are growing numbers of men with eating disorders, eating disorder services remain predominantly tailored to the needs of women. Men and women with eating disorders have distinctly different goals for body image, with men desiring increased muscularity and muscle definition and women tending to focus purely on weight loss. Therefore, the treatment needs of men with eating disorders may be distinct from those of women.

The challenges for therapists working in eating disorder services have been well documented in the literature (Zerbe, 2008, Warren, Crowley, Olivardia & Schoen, 2009). However, the experiences of therapists working with men with eating disorders have yet to be explored. The present study aims to address this gap in the literature. Semi-structured interviews were conducted with six psychological therapists working within a psychodynamic eating disorder service. The interviews focused on the therapists' experiences of working with men with eating disorders. Thematic analysis identified three themes; 1. Lack of experience; 2. Gender; sexuality and gender development and 3. Therapeutic processes; understanding and managing feelings. Suggestions for future research and clinical implications for the treatment of men with eating disorders are discussed.

2.2 Introduction

In order to set the scene for the present study, definitions and prevalence of eating disorders are discussed. Masculinity and help-seeking, how men with eating disorders differ from women and gender specific treatment approaches are discussed. The importance of the therapeutic relationship in the treatment of eating disorders and experiences of staff working with eating disorders clients are then described before the rationale and aims for this study are proposed.

2.2.1 Definitions of Eating Disorders

Eating disorders are complex mental health problems associated with a range of psychological and physical characteristics (Openshaw, Waller & Sperlinger, 2004). Within the DSM-IV (American Psychiatric Association, APA 1994) eating disorders are divided into three categories: Anorexia Nervosa, Bulimia Nervosa and Eating Disorder Not Otherwise Specified (EDNOS).

Anorexia Nervosa is characterised by an intense fear of gaining weight, combined with significant body image disturbance, resulting in an individual's weight being significantly below that expected for the person's height (APA,1994).

Bulimia Nervosa is characterised by extreme weight concern with recurrent binge eating over a discrete period of time (APA,1994). In order to prevent weight gain, compensatory behaviours such as self-induced vomiting are used (APA, 1994).

EDNOS (APA, 1994) is a diagnostic term used for those cases of clinical severity that do not fulfil the diagnostic criteria for either Anorexia Nervosa or Bulimia Nervosa.

2.2.2 Prevalence Rates of Eating Disorders

Hudson, Hiripi, Pope & Kessler (2007) report a lifetime prevalence of Anorexia Nervosa of 0.9% in women and 0.3% in men. The lifetime prevalence of Bulimia Nervosa was found to be between 4.2% and 2.8% for women and between 1.5% and 0.5% in men. EDNOS represents the most common eating disorder in women (Machado, Machado, Gonçalves & Hoek, 2007) with prevalence of 2.37% in women but only 0.03% in men (Beekley, Byrne, Yavorek, Kidd, Wolff & Johnson, 2009).

2.2.3 Prevalence of Eating Disorders Among Men

The true prevalence of eating disorders in men is difficult to ascertain due to likely under-reporting by patients and poor diagnosis by G.Ps (Flahavan, 2006). Often men presenting to frontline healthcare services with eating disorder symptoms are misdiagnosed with depression. Consequently, only the most severe cases of eating disorders are diagnosed and go on to present for

treatment (Chambry & Agman, 2006). The beating eating disorder website (B-EAT, 2012) reports that the Department of Health figures for eating disorders prevalence show only hospital admissions. Therefore, these figures only capture a very small percentage of cases, as only the most severely ill will receive inpatient hospital care.

Due to this, the true prevalence of eating disorders in men is still unclear and further research is required in order to clarify the figures suggested. For example, recent research suggested an increase in men diagnosed with eating disorders (Hudson, Hiripi, Pope Jr & Kessler, 2007, Braun, Sunday, Huang & Halmi, 1999). However, Button, Aldridge & Palmer (2008) found that between 1987 and 2007, out of a total of 2554 eating disorder patients assessed, only 128 (5.0%) were male. They also reported no significant difference in the proportion of males in those two decades. The latest figures published in July 2011 from the Royal College of General Practitioners (RCGP) indicated there had been a 66 % rise in male eating disorder related hospital admissions in England over the past ten years. The RCGP therefore advised GPs to be more aware of the potential presence of the condition among male patients.

2.2.4 High rates of Homosexuality in Men with Eating Disorders

It is suggested that on average between 20% (Andersen, 1999) to 42% (Russell & Keel, 2002) of males with eating disorders are homosexual. One explanation for this is that homosexual men experience greater peer pressure to be physically appealing resulting in higher rates of body dissatisfaction (Boroughs &

Thompson, 2002). Consequently, there is an overrepresentation of homosexual men present in eating disorder services (Hospers & Jansen, 2005).

2.2.5 Masculinity and Help-Seeking in Men

Mahalik, Good & Englar-Carson (2003) suggest that the masculinity literature offers an insight into men's help-seeking attitudes and behaviours. Masculinity has been defined as 'the trait of behaving in ways considered typical for men; manliness and virility' (Collins Thesaurus of the English Language, 2002). Masculinity is correlated with fewer attempts to seek psychological help, Greenberg & Schoen (2008). Men with eating disorders also face the additional challenge of acknowledging a condition that is traditionally seen by society as a 'women's problem'. This may represent an emasculating process, consequently discouraging men from discussing eating and body concerns with professionals and therefore not accessing eating disorder services (Carlat, Camargo, Herzog 1997, Weltzin, Weisensel, Franczyk, Burnett, Klitz & Bean, 2005).

Mahalik, Good, Englar-Carlson (2003) found that men are less likely than women to seek psychological help across nearly all diagnostic categories of eating disorders. By the time male eating disorder clients do reach eating disorder services, they have been found to have a higher incidence of co-morbid psychiatric disorders (e.g. depression, social anxiety or obsessive–compulsive disorder) compared to women (Woodside, Garfinkel, Lin, Goering, Kaplan, Goldbloom, Kennedy, 2001; Carlat, Camargo & Herzog, 1997 and Striegel-Moore & Bulik, 2007).

2.2.6 How are Male Eating Disorder Clients Different?

Andersen (1999b) highlights the importance of acknowledging and appreciating the differences between eating disorders in men and women, and the need to adapt psychological approaches accordingly. Andersen & Mickaldie (1983) suggest that *'Above all, the special needs of the boy or man should be respected. It is unhelpful and demeaning to treat male anorexic clients as if they were teenage girls'.* (page 1069).

As men are socialized to believe muscular men are more masculine and attractive than those less muscular (Andersen, 1999), men strive for increased muscle mass and muscle definition, whereas women often strive for weight loss. Consequently, Weltzin, Weisensel, Franczyk, Burnett, Klitz and Bean (2005) argue that men are significantly more likely than women to use steroids and to over-exercise (Hay, Loukas, & Philpott, 2005) in order to increase muscularity.

Male eating disorder clients are also more likely to have higher rates of alcoholism and substance misuse compared to women clients (Striegel-Moore, Rossello, Perrin, DeBar, May & Kraemer, 2009). It has been suggested that men use these behaviours in order to make their eating disorder symptoms more manageable as they are less likely to receive diagnosis and treatment for their eating difficulties (Striegel-Moore et al, 2009).

2.2.7 The need for research into eating disorders in men

It has been suggested that the focus of existing eating disorder research on females may influence how clinicians approach the treatment of men with eating disorders, (Siegel, Hardoff, Golden & Shenker, 1995). As previously mentioned, there are significant differences between men and women with eating disorders, Andersen and Mickalide (1983) suggest these differences should be explored in future research to better inform treatment approaches. *'It would be a major mistake in understanding anorexic men and women to treat them as if they both fitted within a single stereotyped clinical picture.'* (page 1067).

2.2.8 Do Men With Eating Disorders Require a Different Approach?

As men are often hesitant to access psychological support, Cochran & Rabinowitz (2003) attempted to enhance clinicians' sensitivity and skills in treating male depression. Gender-sensitive interventions acknowledge men's vulnerability to psychological distress when certain gender role expectations are not achieved. Cochran & Rabinowitz (2003) suggested men experiencing depression encounter cultural expectations emphasising stoicism. The suppression of emotion is transmitted through maxims such as 'big boys don't cry', impinging upon men's capacity to manage psychological distress. Gender-sensitive approaches attempt to counteract this by viewing psychological distress in men as a natural, unavoidable consequence of making and breaking attachments, hence treatment is not something to be avoided.

As is the case with depression, the number of men with disordered eating symptomatology is higher than the figures for those accessing services would suggest (Button, Aldridge & Palmer, 2008). Greenberg and Schoen (2008) and Soban (2006) suggested eating disorder professionals working with men should look at Anorexia Nervosa as a cultural issue with unique features related to the social construction of masculinity. They recommend the use of gender-sensitive psychotherapeutic approaches in order to capitalise on the positive aspects of male socialisation and understand the ways in which masculinity influences decisions to seek help. Cochran and Rabinowitz (2003) and Andersen (1986), for example, suggest mental health professionals acknowledge male clients' entry into therapy as evidence of exercising control and acting as a springboard for promoting change.

2.2.9 Therapeutic Relationship in Treatment of Eating Disorders

The importance of the therapeutic relationship in the treatment of eating disorders has been highlighted by de la Rie, Noordenbos, Donker and van Furth (2008) and Zeeck and Hartmann (2005). de la Rie et al (2008) suggested that clients found the therapeutic alliance important because engaging in therapy is particularly challenging for this client group. For example, clients with eating disorders often experience interpersonal difficulty in trusting therapists and may struggle to share power and control with the therapist (Kaplan & Garfinkel, 1999; Sallas, 1985).

2.2.10 Experiences of Working with Eating Disorder Clients

The complexity, co-morbidity and resistance to treatment of eating disorder clients, results in high rates of stress and frustration for clinicians (Warren, Crowley, Olivardia & Schoen, 2009, Ramjan, 2004; Ryan, Malson, Clarke & Anderson, 2006, Kaplan & Garfinkel,1999). Due to the complexity of eating disorders work, Emmett & Rabinor (2007) describe it as 'the impossible profession' (page 81).

Brotman, Stern and Herzog (1984) studied emotional reactions of 29 doctors (House Officers and Psychiatrists), towards hypothetical patients with either Anorexia Nervosa, Diabetes or Obesity. Findings suggested hypothetical Anorexia Nervosa patients generated more anger, stress and helplessness in doctors than the other patients. 67% of participants believed their negative emotional reactions towards Anorexic patients could potentially influence the quality of the care they would provide.

Burkett & Schramm, (1995) assessed the attitudes of 90 therapists (Psychiatrists, Clinical Psychologists, Counselling Psychologists, Social Workers and Nurses) towards eating disorder clients. 31% of the therapists indicated a reluctance to treat people with eating disorders, due to a combination of counter-transference issues, resistance to treatment, co-morbidity and the excessive time demands involved with these cases.

Research investigating therapists' experiences suggests that working with eating disorders increases therapists' awareness of their appearance and feelings about

their body (Shisslak, Gray & Crago, 1989, Warren, Crowley, Olivardia & Schoen, 2009).

Although the difficulty for therapists working in eating disorder settings is widely acknowledged in the literature, no study to date has addressed therapists' experiences of working specifically with male eating disorder clients.

2.2.14 Rationale for Current Research

Research has started to explore therapists' experiences of working with female eating disorder clients. This has highlighted the complexities and demanding nature of this work (Warren, Crowley, Olivardia & Schoen, 2009, Brotman, Burkett Schramm, (1995) Hamburg & Herzog, 1990; Shisslak, Gray & Crago, 1989). However, research to date has not explored therapists' experiences of working with men with eating disorders. This is of increasing importance with evidence indicating that the numbers of men with eating disorders are rising (Hudson, Hiripi, Pope Jr, Kessler, 2007, RCGP, 2011). Male eating disorder clients also demonstrate differences in symptomatology compared to females, in particular, methods of weight loss, cultural and gender expectations, routes to services and co-morbidity (Andersen, 1999b, Weltzin, 2005). These differences suggest that male client experiences, and therefore those of the therapists treating them, may be significantly different to those of females. The experiences of therapists who treat men with eating disorders have yet to be explored and forms the focus of this study.

2.2.15 Aims

The present study aims to explore therapists' experiences of working with male clients in an eating disorder service; clinical recommendations relevant for treatment and suggestions for future research will be discussed.

2.3 Methodology

2.3.1 Ethical Approval

Prior to the research being conducted, full ethical approval was obtained from the Coventry University Ethics Committee, West Midlands Research Ethics Committee and the local NHS R&D Committee (see Appendix G). As is recommended by the British Psychological Society guidelines, informed consent was obtained from participants and all information was anonymised and stored confidentially (BPS, 2005). All data stored on a computer was anonymised and password protected. Prior to interviews being conducted, all participants gave both their verbal and written consent. This included consent to use anonymised verbatim quotations from participants' transcripts in this study. Participant interviews took place between December 2010 and February 2011.

2.3.2 Design

This study utilised a qualitative design; semi-structured interviews were conducted with six therapists to explore their experiences of working with male eating disorder clients. A qualitative methodology was deemed appropriate due to the lack of existing research in this area and because qualitative methods are particularly suited to uncovering meanings that people assign to their experiences (Henwood, Pidgeon, Camic, Rhodes & Yardley, 1995).

2.3.3 Participants and Recruitment

One male and five female participants were recruited from a local eating disorder service. The sample comprised Clinical Psychologists, Nurse Therapists and Psychiatrists. All six participants had completed psychodynamic training to varying levels, received psychodynamic supervision and worked clinically from a psychodynamic perspective with their clients.

The main inclusion criterion for this study was that all participants had a minimum of twelve months experience of direct clinical contact with male eating disorder clients. This was deemed sufficient time to allow participants to draw on and reflect upon their experiences. The participants in this sample had between three and sixteen years experience of working in eating disorder services.

Potential participants were sent written information explaining the broad aims of the research and were asked for their consent to participate. If they agreed, they

sent an Information Sheet (see Appendix C) detailing the main aims of the study, the researcher's contact details and a written consent form (see Appendix C).

2.3.4 Data Collection

A semi-structured interview schedule was developed as recommended by Braun and Clarke (2006) and Giles (2002). The interview schedule contained questions around four topics: engagement and alliance; endings and outcomes; thoughts about therapist gender and suggestions for providing a service for male clients. The interview schedule was used flexibly as a guide to allow the direction of the interview to be led by the participant. Each participant was interviewed by the principal researcher, who had experience in conducting clinically sensitive interviews.

Participant interviews were conducted in a private room at the participant's workplace. Each interview began with an explanation of the purpose and procedure of the research and a discussion of ethical issues, including voluntary participation and the possible publication of any data. At the end of each interview, there was an opportunity for debriefing. The interviews ranged in duration from thirty minutes to one hour.

The interviews were tape-recorded and transcribed verbatim by the Principal Investigator. The principal investigator used the Atlas Ti computer software package in order to assist the coding process as recommended by Kelle (2004). Guidelines and recommendations for good practice in qualitative research

proposed by Henwood & Pidgeon (1992) and Elliot, Fischer & Rennie (1999) were followed. For example 'credibility checks' (Elliot, et al. 1999), were conducted with the Principal Investigator and supervision team inspecting the data themes at various points, discussing differences and similarities in the emerging themes. The Principal Investigator used a research diary throughout, as suggested by Henwood & Pidgeon (1992). This enabled the recording of ideas of themes emerging, being mindful of how the Principal Investigator's own beliefs may have impacted on interpretation of the data.

2.3.5 Data Analysis

Data was analysed using the Thematic Analysis procedure suggested by Braun and Clarke (2006). The task of the researcher is to identify a limited number of themes which adequately reflect their textual data (Aronson, 1994).

Firstly, the chief researcher transcribed the data from the recordings of each participant interview (see appendix D for an example of an interview transcript). This process enabled the Principal Investigator to become fully familiarised with the data. The second stage involved generating the initial codes; i.e. the application of brief verbal descriptions to small chunks of data, (Braun & Clarke, 2006). It also included coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code. The third stage of thematic analysis involved searching for themes; collating codes into potential themes and gathering all data relevant to each potential theme. These themes were then reviewed to check if they worked in relation to the coded

extracts (Levels 1 & 2). This results in developing thematic maps of the analysis. The final thematic map derived from the analysis can be seen in the results section (page 116). The initial and developed thematic maps are presented in Appendix F. The fifth stage included the ongoing analysis and refinement of the specifics of each theme, generating clear definitions and names for each theme. The final stage was the production of a report, including the use of selected extracts that most accurately reflected the themes derived from the data.

2.3.6 Subjectivity and Reflexivity in the Research Process

As Elliot, Fischer and Rennie (1999) suggested when conducting qualitative research, 'a researcher should 'own one's perspective.' (page 221). This involves recognising the influence that the researcher's values and position has on the interpretation of the data.

The first influence considered was that the Principal Investigator was on a Clinical Psychology placement within the eating disorder service from which participants were recruited. It was acknowledged that as a male Trainee Clinical Psychologist with a clinical interest in men with eating disorders and psychodynamic approaches, this may have influenced the data analysis process. In order to attempt to address this, the author met with fellow Clinical Psychology Trainees using a similar research methodology to conduct 'credibility checks' on the data to ensure validity of the analysis. At these meetings, discussion of and reflections on the developing themes also took place.

2.4 Results

Table 2: Table of themes and codes derived from analysis of data

Theme	Codes
Lack of Experience	Perceived lack of male clients accessing services. Societal & cultural barriers to access Professional barriers to access
Therapeutic Processes; Understanding and Managing Feelings	Transference and counter transference Working with client's defences
Gender, Sexuality and Gender Development	Therapist reactions to gender of client Therapist gender and its perceived relationship to engagement. Perceived prominence of sexuality in clinical work Eating Disorders as a means of preventing male gender development

2.4.1 Theme 1: Lack of experience

2.4.1.1 Subtheme: Perception of a lack of men accessing services

All six participants discussed their limited experience of working with men with eating disorders. They reported their lack of experience was due to the small number of men accessing their eating disorder service:

> *'I don't know where they are going but they are not coming here' (P3;16).*

Participants discussed how the very low numbers of men in their service did not correspond with the higher figures of male clients in eating disorder services suggested in the wider research:

> '*We have a tiny number of men arriving for treatment in this service, far fewer than the research out there would suggest'. (P2; 56).*

Explanations offered by participants attempting to explain the low number of men accessing eating disorder services are captured in other themes and explored further in later sections.

2.4.1.2 Subtheme: Societal & Cultural Barriers to Access

All of the participants perceived that it was more difficult for men to access eating disorder services than for women. Participants went on to suggest that disclosure of an eating disorder was more difficult for men due to the societal and cultural stigma about what it is to be male:

> '*it's more difficult for young men to access those type of services... fundamentally there is still more stigma to come forward sooner'. (P3; 47-49).*

A similar view is expressed by Participant 4 when discussing one of the male client's difficult experiences in disclosing his eating disorder:

> '*he very much felt he had to be the breadwinner, the lead, the strong one at home and actually he didn't raise the illness because he felt it would look weak on him if he wasn't presenting the male role'. (P4; 27).*

Participant 2 suggested the stigma preventing men accessing eating disorder services is based on the cultural ideas of what it is to be a man and how much more difficult it must be for a man with eating disorders to seek help:

'*it still does feel like it might be more of a stigma for men to acknowledge that they are making themselves sick, it doesn't go with being a man in our culture does it..... must be very very difficult, if it's difficult for a woman to go to her GP and say I am making myself sick it must be a hundred times more difficult for a man'.* (P2; 69-72).

Participants also acknowledged the wider societal assumption that people with eating disorders are female:

'*I imagine it must be extremely difficult, to be a man with a girl's problem when coming into a service like this'. (P2; 57).*

In line with this, several participants described how they perceived that men's symptoms of disordered eating are hidden and not recognised, as society does not associate men with experiencing eating disorders:

'*I think it's more hidden and maybe not even noticed so much by the colleagues and friends that they have, because it's not associated with males' (P4; 25).*

Participants discussed the perceived societal and cultural barriers men face accessing eating disorder services. In order to improve recognition, diagnosis and acceptance of men with eating disorders, a wider societal and cultural awareness is required. One participant suggested the media could assist the promotion of this awareness.

'I guess what I am thinking about is more awareness....more stories in soap operas, maybe the Archers..we have got a (female) anorexic Archer, I think we need a male bulimic Archer' (P2; 79).

2.4.1.3 Subtheme: Professional Barriers to Access

As well as societal and cultural barriers participants also described the limitations of professional healthcare services may prevent men from accessing eating disorder services. For example, one participant described how she believed that, historically, services have been tailored to the needs of women and that this may lead to fewer male clients accessing services:

'*inevitably services have grown up around the needs of women, which may not be the same as the needs for men, there are so few men coming into services that I think they are more likely to miss out or drop out rather than be able to shape services'.(P2;68).*

Participants suggested that male clients must take a different access pathway that prevents men getting to their service:

'*there must be some differences.....that is offered at some point in the pathway, there is something that is keeping male patients from getting to this service'.(P2:72).*

Participant 3 also discussed how the services at present were predominantly treating female clients but that she did not want this to impact on how the service is perceived by her fellow professionals:

> *' I don't want ourselves to think about ourselves as exclusively a women's service'. (P3:55).*

Participant 4 discussed the lack of male clients in eating disorder services was due to a lack of training and poor recognition of male eating disorders from frontline healthcare staff such as General Practitioners:

> '*I think GPs' assessments, their knowledge of eating disorders is very limited, in their training etc, I think they need to be looking for, you know, this is in men as well.....because they are still very minimal in numbers aren't they, if you think of us as a team here, I don't ever recall ever having more than one male person in at a time' (P4;32-33).*

2.4.2 Theme 2: Therapeutic Processes; Understanding and Managing Feelings

As the participants worked psycho-dynamically with clients, regular reference to psychodynamic principles were made in the interviews. This theme captures the participants' emotional responses to their male clients.

2.4.2.1 Subtheme: Transference

The significance of the mother-son transferential dynamic between a male client and a female therapist was discussed by Participant 3:

> *' I have learnt that men find it difficult to work with a woman who they see as having power over them.....this is an incredibly powerful dynamic for them because there is such a transferentially important dynamic between a young boy and their mother that the room is an incredibly powerful place to be'. (P3;63).*

Participant three's experiences here could be linked to evidence that the trends in the families of anorexic males suggest the over identification of the anorexic son with his mother, and the mothers as often overcontrolling (Fichter & Daser, 1987; Sterling & Segal, 1985).

Participant Three goes onto describe in more detail the 'powerful dynamic' by identifying that male eating disorder clients may experience significant difficulty and fear about disclosing vulnerability. Participant three suggested that male clients' react against this in therapy with female therapists by blaming and attacking others:

I think a lot of it underneath it all is fear and what they can't easily say to people is 'I'm scared' what they say to people is 'it's your fault what are you doing to me?' to make themselves vulnerable is incredibly difficult. (P3:65).

Other participants talked about how they perceived that the clients, not the therapists, were anxious about the transference processes:

' *I think if he had a choice as to what gender therapist to have, he would have chosen a male, but I think that was because he was more scared about the feelings in the maternal transference'. (P3;34).*

2.4.2.2 Subtheme: Counter-transference

Several participants discussed the process of counter-transference. For example, Participant 3 commented on her counter-transference reaction to difficult client feelings:

'*he was probably the most bitter and poisonous person I had to work with; he was really toxic.....He would be really really unpleasant in such a way that I don't think I have ever had and I have never felt as angry with somebody as I felt when I was with him'. (P5;37-42).*

Participant 6 commented on paternal counter-transference reactions experienced with male clients:

> *'I was very aware with the male clients particularly, of the paternal counter-transference....it seems to be quite often the case definitely in my experience of male clients.....there is often a lack of a strong father figure.....lack of a person against who they can rebel against safely.....I was very conscious of the unconscious pressure to be the absent father'. (P7; 29-35).*

One participant experienced strong counter-transference reactions to all the male clients they worked with, something they had not experienced with female clients:

> *' in terms of counter transference I have experienced much more irritation with the males that I have seen than I typically do working with women. I can get very irritated but it's quite unusual for me....with the male clients I see.....irritation has been my companion throughout'. (P2;23-25).*

2.4.2.3 Subtheme: Working with Clients' Defences

Some of the participants interviewed described their clinical experiences of working with male clients who strongly defended against therapeutic interventions. Participant 3 described how one male client's defence was to repeatedly attempt to belittle the importance of the clinical contact with her:

'he was very difficult, he was really hostile, extremely difficult to be in a room with ...he was trying to get me off his back, he thought it was a joke coming to see me so he didn't take it seriously,....so I had lots of difficult feelings, because I felt incompetent and I felt angry with him because he obviously saw coming to see me as a joke. Which as a professional isn't a particularly nice feeling…it was an extremely difficult experience to not get on with somebody at all' (P3; 25).

Participant 3 went on to explain her perception of why this particular client defended so aggressively against her:

' I think he was so uncomfortable in the room with somebody trying to get into him in some way....that he just kind of rebelled against and did everything he could to get out of the room really by making it so unbearable for me that I would just let him go kind of thing'. (P3; 27).

Participant 1 described her experience of working with a male client's perceived defences as he requested less frequent sessions:

'it was very difficult.....I think he was the one that put the barriers up...he decided to knock the frequency of the sessions on the head and wanted to come back every two weeks.....I think it became safer and more in control when he asked for fortnightly sessions. I think he felt safer with that so there was a bit more distance'. (P1;39).

2.4.3 Theme 3: Gender, Sexuality and Gender Development

2.4.3.1 Subtheme: Therapist reactions to gender of client

All of the participants reported that the majority of their clinical experience in eating disorders was with female clients. Working with male clients was a relatively less familiar experience for participants. For Participant 1, this meant her anxiety increased:

> *' I did feel quite anxious before meeting with the male client I worked with, because it is something different, I don't know, in a service that is predominately for women, I suppose you become more comfortable with what you know'. (P1;11).*

Some participants described how working with male clients was a distinctly different experience for them:

> *' it is striking when you are working with a man with an eating disorder because you don't often see it so you do feel quite different'.(P4;17)*

Participants described questions raised due to the rarity of male clients:

> *' with a man you think why have you got an eating disorder because it is so unusual.....you, are kind of questioning why it is a man has an eating*

disorder.....it feels special, unusual, different and so it does kind of raise your interest'. (P1;9-16).

The impact of this unfamiliarity expressed in terms of confidence about working clinically with male clients compared to the familiar female clients is discussed by Participant 2:

' my response to taking on a male client I think I tend to be reluctant, I tend to stand back rather than step forward because I feel less confident of my ground.....I don't feel confident and therefore I not to approach it very enthusiastically'. (P2;55).

2.4.3.2 Subtheme: Matching Therapist & Client Gender

Participants were asked for their views about whether therapist and client gender should be matched. All participants described that they thought that therapist gender should not be matched to client gender, for example, Participant 5 said:

'*I strongly believe it should be about trying to match people as opposed to gender'. (P5;53).*

In fact, some participants talked about the perceived advantages of having a therapist of opposite gender to the client:

'*I can see there is an advantage for a girl who is afraid of men having a good therapeutic relationship with a man... they could miss out on something if they were never offered that opportunity'. (P3;59)*.

Participant 4 was adamant that therapist and client gender should not be matched as each individual relates differently to gender:

' No I think it's better that the therapist feels comfortable for any patients coming through, my personal opinion is that we all relate differently to different genders don't we?' (P4; 37).

2.4.3.3 Subtheme: Perceived prominence of sexuality issues

The majority of the participants reported a significant focus on the topic of sexuality in clinical work with male clients, which differed from their experience of female clients. Participant 2 discussed her perception that unlike her work with female clients the topic of sexuality being a central aspect of the therapeutic work with male clients:

' *some I have worked with, exploring sexuality has been part of the work but only a very small minority, whereas with a few men it has been a prominent feature of work, that's quite a clear difference actually'. (P2; 53-55)*.

As a result of the perceived prominence of the topic of sexuality in the work with male clients Participant 3 discussed what she had learnt from this:

> *'I definitely got more aware of sexuality in my time working with men'. (P3;L46)*

Participant 6 reported similar experience of learning more about the link between sexuality and eating disorders from the clinical work with male eating disorders:

> *'The one thing I have learnt about (in my time working with men) is the link between sexuality and eating disorders'. (P6;52).*

Participant 6 went on to describe the lack of clinical discussion of clients' sexuality and the topic of homosexuality and yet this appears to be an important issue for male clients:

> *'sexuality is an area that is around a lot in the literature in relation to women although it strikes me how rarely we talk about it in clinical practice .....probably because we reflect our patients difficulty in acknowledging their sexuality, and I think that's very much an issue with male patients'. (P6;54).*

Participant 6 discussed the high prevalence of homosexual men with eating disorders and the link between Bulimia Nervosa and homosexuality and the increasing body pressures on homosexual men:

'what does seem to be likely is that there is more bulimia in the gay population and you can certainly tell a plausible story about the pressures on gay men to have an attractive body, this may be stronger than in the homosexual community; which might explain how eating disorders in gay men develop'.(P6; 27).

2.4.3.4 Subtheme: Eating Disorders as a means of delaying male gender development.

Several participants perceived the eating disorder symptomatology they saw in male clients was a means of delaying male sexual development. Participant 3 described the experience of working with a man who delayed puberty through suppressed eating in an attempt to stay pre-pubertal:

'This is the young man who turned twenty.....but you would have thought he was actually thirteen. He hadn't actually gone through puberty at all because...his development had been so delayed by years of suppressed eating'. (P3,35).

'There was a great fear of what was going to happen to him....he didn't want to eat red meat, which we interpreted as him being worried about becoming stronger and.....he was obviously scared of himself becoming a

man for some reason and he wasn't comfortable with that at all. He wanted to stay looking like a young boy' (P3, 39-41).

Participant 6 also discussed the idea that some men suppress their eating as a way of dealing with unwelcome sexual feelings that emphasise their identity as men:

'what I have learnt about really is the way in which suppressing bodily appetites and suppressing sexual development through starvation can be a way of dealing with problematic sexual feelings and difficulties around being a male; a man as opposed to a boy…. male patients wanting to stay a little boy pre-pubertal'.(P6; 22-24).

Finally, Participant 4 discussed how eating disorder symptoms may mask the issues of gender identity and sexual development: Participant 4 gave the example of working with a biological male client who, after a significant amount of time in the service, confided in therapy that he wanted to undergo gender reassignment:

'This is somebody I saw for ten years or so.....part of the way through this he expressed that he really wanted to be a woman, he began dressing as a woman and eventually he had a gender reassignment'. (P4;19-20).

Participant 4 discussed her perception of the role of eating disorders in this case:

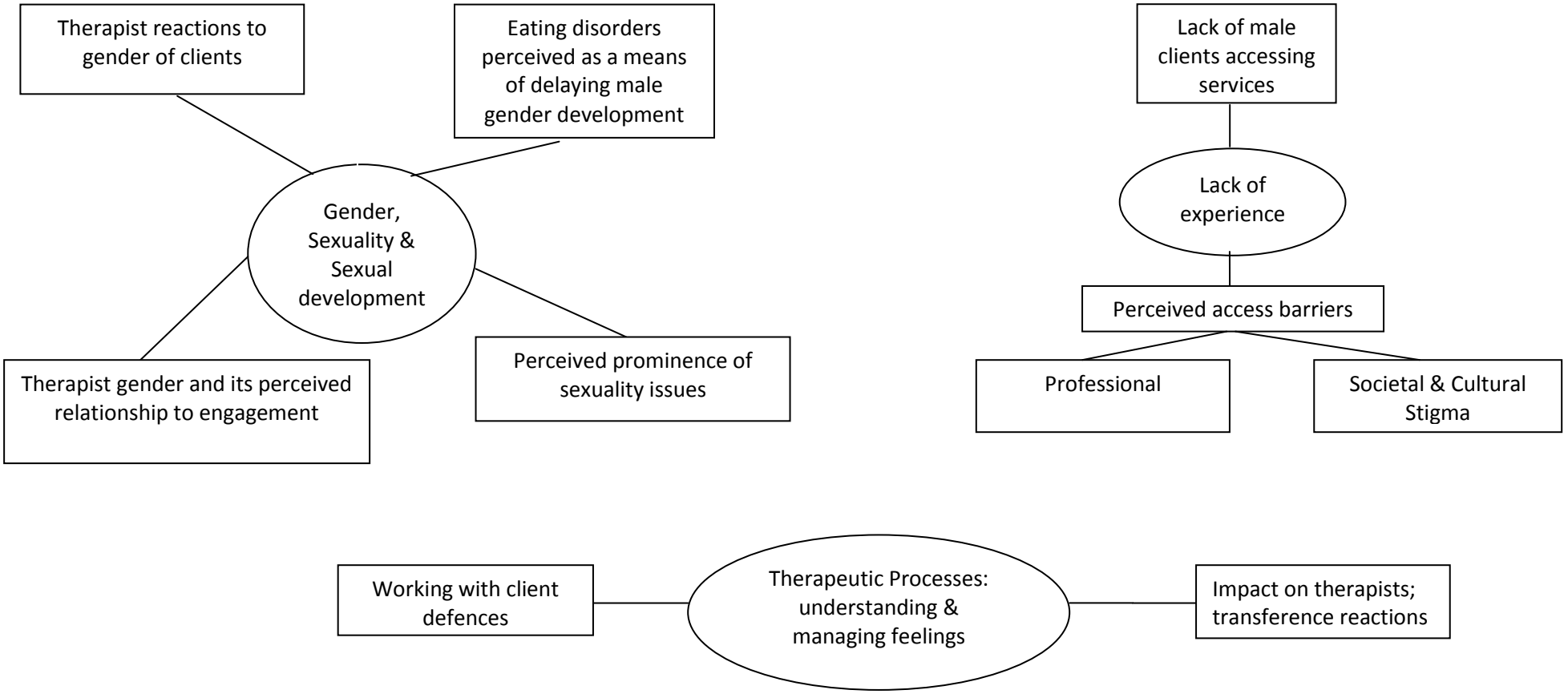
'I think the eating disorder had masked this (gender identity issues) and it was the eating disorder that he initially presented to us in the referral to our service' (P4: 45).

Participant 4 described this as something she had not previously encountered in her substantial experience of working with female clients but the importance of trust in working with this client through the gender re-assignment process:

'I had no experience of this area.....I think that trust element enabled him to broach the subject of sexual orientation.....particularly going through the gender re-assignment operations that they go through...you know we talked about very private sexual things' (P4:39-40).

' I think that trust element enabled him to broach the subject of sexual orientation and gender reassignment at a further point and actually appreciated people being up front and honest and accepting him for who he was which I think the eating disorder had masked'. (P4:46).

Figure 1: Thematic Map of Results



2.5 Discussion of Thematic Map

2.5.1 Lack of experience

All of the participants reported lacking experience of working clinically with men with eating disorders. Some participants referred to research indicating an increase in the number of male clients accessing eating disorder services and that this was not evident in their service. Participants suggested that their lack of experience of working with male clients was due to both societal stigma and professional barriers that either in isolation or in combination prevented men from accessing services.

2.5.2 Therapeutic Processes

Participants discussed their experience of the therapeutic processes; working with clients' defences against the therapeutic process and the importance of understanding and managing feelings. Participants also discussed their transference reactions generated and projected by their clinical work with men.

2.5.3 Gender, Sexuality and Gender Development

Due to their limited experience of working with men, participants reported that the arrival of male clients in their service provoked anxiety, as they were more familiar working with female clients. Participants expressed the view that being the same gender as the client may initially assist early engagement, but that therapists who were the opposite gender to the client could potentially be useful and also bring

different transference issues to the fore. However, all the participants strongly advocated that client and therapist gender matching should not routinely take place.

Participants also discussed their perception that the discussion of sexuality and issues around sexual development were significantly more prominent in clinical work with male clients compared to female clients. Several participants discussed their experiences of working with male clients and how in some cases they perceived eating disorders as a means of delaying male gender development.

2.6 Discussion and Conclusions

Thematic analysis of interviews with six eating disorder therapists working psycho-dynamically with male clients yielded three main themes: lack of experience; gender, sexuality and gender development; and therapeutic processes, understanding and managing feelings (see Figure 1 page 132). Clinical and methodological issues are considered and ideas for future research are proposed.

2.6.1 Summary of Results

2.6.1.1 Lack of experience

All participants reported having relatively limited experience of working with male clients due to the small number of men accessing eating disorder services. Participants did not report any increase in the number of male clients accessing their service in the past decade. This supports the findings of Button, Aldridge and

Palmer (2008) who found that between 1987 and 2007, out of 2554 eating disorder patients studied, only 128 (5%) were male and there was no significant difference in the proportion of males in those two decades.

2.6.1.2 Barriers to Male Clients Accessing Services

It is suggested that men, regardless of their condition, have difficulty accessing any form of mental health services (Mahalik et al, 2003). However, participants perceived there to be additional barriers for men to overcome in order to access eating disorder services.

2.6.1.3 Social Stigma as a Barrier to Access

Participants suggested that men face the additional social stigma of experiencing eating disorders as Weltzin et al , (2005) suggested that this is viewed by society as a 'women's' disorder', (page 189). As a result of this, male eating disorder clients in an attempt to manage eating disorder symptoms are more likely to have higher rates of alcoholism and substance misuse compared to female clients (Striegel-Moore, Rossello, Perrin, DeBar, May & Kraemer, 2009),

2.6.1.4 Professional Barriers

Participants described referrals of men to their service as being very rare and suggested this was a consequence of the poor recognition and diagnosis of male

eating disorders by General Practitioners. Andersen & Mickalide (1983), suggest that as a result of poor awareness, doctors often launch an extensive medical investigation into alternative explanations of male weight loss. A consequence of this may be that only men with the most severe eating disorder symptoms receive treatment (Chambry & Agman, 2006).

Although not a barrier to men's diagnosis and access to services, participants also suggested that their limited clinical experience of male eating disorders may be a barrier to male clients receiving the most clinically useful intervention once in services. This lack of experience is exacerbated by the service provision not being designed with the needs of men in mind. Participant 2 discussed how services have grown up around the needs of women, which may not be the same as the needs for men (page 120). Participant 2 went on to say that there must be some differences in what services are offered at some point during the pathway and this may partly explain the barriers to men accessing this service.

This highlights a need for additional training and awareness of male eating disorders, not just to wider healthcare professionals but also to staff working in eating disorder settings in order to inform service design and delivery.

2.6.1.5 Gender, Sexuality & Gender Development

The themes of gender, sexuality and gender development were repeatedly present in participant interview. Participants highlighted the importance of these themes when working clinically with men with eating disorders.

2.6.1.6 Gender

All of the participants discussed the impact of client gender and therapist's own gender on their clinical experiences. The only male participant felt that his gender was an advantage in the initial engagement process with male clients, whereas female participants felt that their gender may have been a barrier to engagement with men. The idea of same gender therapists being more suited for eating disorders is discussed in the literature (Bilker, 1993 and Burkett & Schramm, 1995). Bilker (1993) wrote that female therapists like their (female) clients, 'have a greater awareness of body image and a first hand understanding of the emotional, physical experiences of being female'. (page 402). Bilker (1993) concluded that the shared experiences facilitate empathy and give 'the female therapist more credibility with the female patient'. (page 418). However, in this present study several participants also discussed the usefulness of the therapist being of a different gender to that of the client.

As all participants used a psychodynamic approach, they also discussed transference reactions (e.g. Kapelovitz, 1987) in relation to gender. Participants identified parental transference being very common amongst all clients. This is the process of the client placing feelings held towards parental figures on to the therapist. It has been suggested that the gender of the therapists is important in relation to the previous experiences of the client (Hughes & Kerr, 2000). For example one participant described men with eating disorders often being raised in female dominated family environments, therefore, having a female therapist was a recreation of that, resulting in difficult transference experiences. Zunnino, Agoos and Davis (1991) suggested that male and female therapists may differ in the

transference and counter-transference interactions with the clients. An improved understanding of how therapeutic processes with clients may vary according to therapist gender could usefully inform clinical practice.

2.6.1.7 Prominence of Sexuality Issues

All of the participants reported that unlike their work with female clients, sexuality appeared to be a central part of clinical work with male clients. Herzog, Norman & Gordon (1984) reported that male patients with eating disorders are likely to experience 'conflicted homosexuality' (page 989). Homosexual men are more likely to be dissatisfied with their body and more likely to desire an underweight ideal, (Williamson & Hartley, 1998, Herzog, Newman & Warsaw, 1991). Homosexual men have a higher risk of disordered eating compared to heterosexual males at five year follow-up (Wichstrøm, 2006) and be overrepresented in eating disorder services (Hospers & Jansen, 2005). The theme of sexuality and its relationship to the development, maintenance and treatment of male eating disorders, therefore, needs to be explored further.

Participant 6 reported that healthcare professionals avoid discussion of sexuality when treating clients (page 129). Research has also suggested that health professionals do not discuss sexually related issues in consultations as often as clients would like (Gott, Galena, Hinchliff & Elford, 2004). Guthrie (1999) found that nurses were reluctant to address issues of sexuality, often avoiding this with patients. Interestingly, Gott et al. (2004) also suggested that if the client is

homosexual, this acted as a barrier to staff discussing sexuality. This is particularly important to consider in eating disorder settings, as the evidence indicates an overrepresentation of homosexual men (Wichstrøm, 2006). Therefore, there is a clinical need for specialist training in working with sexuality in order to improve the clinical care provided.

2.6.1.8 Eating Disorders as a means of preventing male gender development

Participants 1, 3 and 6 discussed their experiences of male clients who had not progressed through pubertal development as a result of their restricted eating. One suggestion from the female eating disorder literature is that delayed puberty is a means of preventing the pubertal physical changes to their bodies, i.e. development of hips and breasts (Herrin & Matsumoto, 2007). The perception of the participants in the present study was that although male clients may have delayed their pubertal development through starvation in order to prevent physical changes, there was also a strong desire to stay in a pre-pubertal state. Participant 6 suggested this may stem from clients' history of being too dependent on their parents, resulting in a fear of maturing sexually and becoming independent. Although this is a process that may not be unique to male clients, it is important to explore how this may be similar or different for male clients in order to better shape clinical interventions.

Participant 4 discussed her experience of working with a male client with eating disorders who, during long term outpatient treatment, underwent gender re-assignment. Both trans-genderism and eating disorders in men are rare; the

prevalence of transgender conditions in men is 1 per 30,000 (American Psychiatric Association, 1994). The lifetime prevalence in men of Anorexia Nervosa is 0.3% and Bulimia Nervosa is 0.5%-1.5% (Hudson, Hiripi, Pope & Kessler, 2007). Hepp & Milos (2001) commented that the combination '*of gender identity disorder and eating disorders in men is low, meaning the coincidence of both disorders is noteworthy'* (page 473).

The literature on gender reassignment or gender identity disorder in men with eating disorders is extremely limited. Surgenor & Fear (1998) described a case of a biological male transgendered patient with Anorexia Nervosa and the close link between transgender issues and eating disorders; 'by virtue of its emphasis on estrangement from body, biological gender, and expected social role, transgenderism may constitute a risk factor for developing an eating disorder in certain men' (page 451). Fichter & Daser (1987) found male patients with Anorexia Nervosa showed several signs of a disturbed psychosexual and gender identity development.

Participant 4 interpreted her transgendered client's eating disorder as a means of 'masking' the gender identity issues the client experienced. Hepp & Milos (2001) hypothesised that transgendered individuals express severe body dissatisfaction and undertake disordered eating behaviour as 'an inadequate strategy to reduce stress and modify the body and sexuality'.(page 476). A greater awareness of the disordered eating patterns of transgendered clients may improve not only clinicians' understanding of gender identity disorders but also of eating disorders in general, (Surgenor and Fear, 1998).

2.6.1.9 Therapeutic Processes: understanding and managing feelings

As all the participants worked from a psychodynamic perspective there was an emphasis on the therapeutic processes, transference reactions and working with clients' defences (Goodsitt,1985). The majority of participants discussed the difficulty of working clinically with men with eating disorders. Golan (2009) has pointed out the demanding nature of working in eating disorder settings and argues that the experience of intense counter-transference reactions can lead to treatment providers' burnout and emotional exhaustion. Therapist experiences of counter-transference issues in the therapy of eating disorder patients included frustration, agitation, anger, helplessness, and boredom. A clinical implication of this is a need to recognise the importance of supervision and support for therapeutic staff in eating disorder settings, in particular acknowledging that strong transference reactions are likely to be experienced. Hamburg & Herzog, (1990), 'therapists benefit from a supervisory attitude of respect and empathy, with specific attention to counter-transference difficulties as they arise, this can be a valuable training tool' (page 378).

2.7 Methodological Limitations

2.7.1 Limited sample size

When considering the results of this study, methodological limitations need to be acknowledged. The main limitation of this study is that the sample is both small and localised. This was partly as a result of the low number of participants meeting the inclusion criteria of having clinical contact with male eating disorder clients.

2.7.2. Lack of saturation

Although the main researcher attempted to represent the viewpoints of the participants through the thematic analysis of the interviews, it could be argued that the researcher did not reach a point of saturation; the point of analysis where no new data emerges.

2.7.3 Use of sample that worked psychodynamically

The participants in this the present study were Psychiatrists, Nurse Therapists and Clinical Psychologists who worked clinically from a psychodynamic perspective. They had all completed varying levels psychodynamic training and received psychodynamic supervision.

It has been suggested that Psychodynamic treatment approaches offer therapists a greater understanding of the cause, adaptive function and purpose that eating disorders serve, Bruch (1973, 1978). Psychodynamic therapies are the most frequently utilized outpatient treatment for Anorexia Nervosa in the United States (Herzog, 1995). In a randomised controlled trial (RCT) of effectiveness of psychological treatments Dare, Eisler, Russell, Treasure & Dodge (2001) found at one year follow up, psychoanalytic psychotherapy was significantly superior to the control treatment: with patients more likely to remain in outpatient treatment than if they are offered routine outpatient treatment. However, only a limited number of RCT's of psychodynamic treatment approaches have been completed due to its lengthy duration and the complex nuances of the technique being difficult to control experimentally, (Bjork,Clinton & Norring, 2006).

The use of a sample that solely used a psychodynamic therapeutic model does not take into account other widely used eating disorder treatment approaches such as Cognitive Behavioural (Fairburn, Cooper & Shafran, 2003) and Systemic Family therapy approaches (Lock & le Grange, 2005). As RCT's have provided a strong evidence base for Cognitive Behavioural Therapy (CBT) and Systemic Family Therapy for Bulimia Nervosa and EDNOS (Russell et al, 1987), future studies should look to evaluate the experiences of therapeutic staff working with these more widely evidenced therapies.

2.8 Implications for Clinical Practice and Future Research

2.8.1 Gender

One participant described current eating disorder research as female focused, this is very evident in psychodynamic research of eating disorders, (Winston, 2006). However, currently there is a lack of research on the therapeutic process of working psychodynamically or from other perspectives with male clients. As Greenberg & Schoen (2008) & Soban (2008) suggested, the client's gender needs to be considered further in research, in order to improve services for male eating disorder services.

2.8.2 Improving Services for Male Clients

Due to the dearth of referrals of male clients to their service, participants proposed the need for frontline healthcare professionals to increase their awareness of male eating disorders. General Practitioners (GPs) have most influence in men accessing therapy (Cusack, Deane, Wilson & Ciarrochi, 2004) therefore GPs' increased awareness may improve diagnosis of male eating disorders.

The prominence of sexuality issues in male clients was highlighted by all participants but it was also acknowledged in literature that professionals struggle to discuss

these issues with clients. Magnan, Reynolds & Galvin (2005) recommend that further training and supervision about working with the topic of sexuality is provided to practitioners.

Participants identified sexuality as a central part of the therapeutic process with male eating disorder clients. This is consistent with previous research findings that homosexual men are at greater risk of developing eating disorders than heterosexual men (Hospers & Jansen, 2005). It is therefore suggested that a greater emphasis should be placed on eating disorder awareness and prevention programmes within the male homosexual community.

2.8.3 Suggestions for future research

This present study explored therapists' experiences of working with male eating disorder clients. However, it is of increasing importance to consider researching male clients' experiences of eating disorders treatment.

The chief investigator initially aimed to research this topic, however, due to a lack of male clients in local services, this was not possible. If future research with male eating disorder clients is to be conducted, a wider variety of recruitment methods could be utilised to maximise sample size. This could be achieved by recruiting both current and former eating disorder service clients and, from a wider a range of services to include both statutory and private sector service providers as well as male eating disorder charities.

A recent study of the treatment experiences of eight men in eating disorder services was been conducted by Robinson, Mountford and Sperlinger (2012). They identified male clients' difficulty of seeing themselves as having an eating disorder, and the importance of gender in treatment. This is a useful step in the right direction but a far greater number of studies on this topic with larger samples are required in order to develop professionals' understanding and to help to shape future services.

2.9 Conclusions

Participants perceived that men have difficulty accessing eating disorder services as a result of societal and cultural stigma and professional barriers such as poor diagnosis. This was seen as contributing to the limited amount of experience of treating male clients with eating disorders. For the male clients in services, participants identified the themes of gender, sexuality and gender development and therapeutic processes as of importance. Recent research suggests men are experiencing increasing pressures regarding body shape, potentially leading to increases in male eating disorders (Dallesasse, Carney, Dagley, Kluck, 2011). Therefore, the study of the process of treatment for male eating disorders, are of increasing clinical relevance. In exploring therapists' experiences of male eating disorder clients, the present study has addressed a previously neglected topic in the literature. Despite methodological limitations, the findings point to important themes and issues of relevance to practitioners in this field, clinical implications and areas for future research directions proposed.

2.10 References

American Psychiatric Association.(1994). *Diagnostic and statistical manual of mental disorders* (4th ed). Washington,DC: American Psychiatric Association.

Andersen, A,E., Mickalide, A.D. (1983). Anorexia Nervosa in the male: An under diagnosed disorder. *Psychosomatics, 24, (12) pp. 1066-1075.*

Andersen, A. E. (1986). Males with eating disorders. *New Directions for Mental Health Services, 31, pp.* 39–46.

Andersen, A. E. (1999a). The diagnosis and treatment of eating disorders in primary care medicine. In P. S. Mehler & A. E. Andersen (Eds.), *Eating disorders: A guide to medical care and complications* (pp. 1–26). Baltimore, MD: Johns Hopkins University Press.

Andersen, A.E. (1999). Eating disorders in gay males. *Psychiatric Annals, 29, pp.206–212.*

Aronson, J. (1994). A Pragmatic View of Thematic Analysis. *The Qualitative Report Vol.2. (1) pp 112-137.*

Atlas-Ti .(2006). Version 5.2. [Computer software]. Gmbh. Berlin.

Banon, E. Evan-Grenier,M.,Bond,M.(2001). Early transference interventions with male clients in psychotherapy. *Journal of Psychotherapy Practice & Research, 10, (2), pp. 79-92.*

BEAT (2000). Online PDF; Eating Disorders In The U.K. Review Of The Provision Of Health Care Services For Men With Eating Disorders. Retrieved from; www.beat.co.uk/AboutEatingDisorders/Mengeteatingdisorderstoo.co.uk.

Beaumont, P. (2000). Anorexia Nervosa as a mental and physical illness – the medical perspective. In D. Gaskill and F. Sanders (Eds.). *The Encultured Body – Policy Implications for Healthy Body Image and Distorted Eating Behaviours.* (pp80-94): Queensland University of Technology, Brisbane.

Becker,D., Mester,R. (1996). Further insights into transexualism. *Psychopathology, Vol. 29,pp.1-6.*

Beekley ,M.D. Byrne, R., Yavorek, T., Kidd, K., Wolff, J., & Johnson, M. (2009). Incidence, prevalence, and risk of eating disorder behaviours in military academy cadets. *Military Medicine,174,(6),pp.637-641.*

Beren, S.E., Hayden, H.A. Wilfey, D.E., & Grilo, C.M. (1996). The influence of sexual orientation on body dissatisfaction in adult men and women. *International Journal of Eating Disorders, 20, pp.135-141.*

Bilker, L. (1993). Male or female therapists for eating-disordered adolescents: Guidelines suggested by research and practice. *Adolescence, 28,(110). pp.393-442.*

Bjork,T.,Clinton,D.,Norring,C.(2006). Reasons for non-participation in follow-up research on eating disorders. *Eating and Weight Disorders,11,(3), Sep 2006, pp. 147-153.*

Boroughs,M.,& Thompson,J. (2002). Body depilation in males: A new body image concern. *International Journal of Men's Health,1, pp. 247-257.*

Braun, V.Clarke,V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology, 3(2) pp. 77-101.*

Braun, D. L., Sunday,S. R., Huang,A., Halmi, K.(1999). More males seek treatment for eating disorders. *The International Journal of Eating Disorders, 25, (4), pp. 415-424.*

Britchnell, S. A., Lacey, J., Harte, A. (1985). Body image distortion in bulimia nervosa. *British Journal of Psychiatry, 47, pp. 408-412.*

British Psychological Society. (2005). *Code of Conduct, Ethical Principles and Guidelines.* British Psychological Society.

Brotman,A.W., Stern,T.A., & Herzog,D.B. (1984). Emotional reactions of house officers to clients with anorexia nervosa, diabetes, and obesity. *International Journal of Eating Disorders, 3,(4),pp.71-77.*

Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa, and the person within*. New York: Basic Books.

Bruch, H. (1978). *The golden cage: The enigma of anorexia nervosa*. Cambridge MA: Harvard University Press.

Burkett & Schramm, (1995) Therapists' attitudes about treating patients with eating disorders. *Southern Medical Journal*. *88, (8), pp. 813-8.*

Button, E. ,Warren, R.(2001). Living with anorexia nervosa: the experience of a cohort of sufferers from anorexia nervosa 7.5 years after initial presentation to a specialized eating disorders service. *European Eating Disorder Review. 9, (2), pp.74-96.*

Button,E., Aldridge,S., Palmer,R. (2008). Males Assessed by a Specialized Adult Eating Disorders Service: Patterns Over Time and Comparisons with Females. *International Journal of Eating Disorders, 41,(8),pp. 758-761.*

Carlat, D.J.,Camargo,J.R.,Herzog,D.B.(1997). Eating disorders in males: a report on 135 clients. *American Journal of Psychiatry, 154, pp.1127-1132.*

Casement, P. (1990). *On Learning from the Patient,* London: Routledge.

Chambry, J., Agman,G. (2006). Masculine Anorexia Nervosa at adolescence. *La Psychiatrie de l'Enfant,49, (2), pp.477-511.*

Charmaz, K. (2006). *Constructing grounded theory a practical guide through qualitative analysis.* London: Sage Publications Limited.

Cochran, S., Rabinowitz, F. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men*. Professional Psychology, Research and Practice, 34, (2), pp. 132-140.*

Collins Thesaurus of the English Language, Complete and Unabridged (*2nd Edition*). (2002). London: Harper Collins Publishers.

Crisp, A.H. T. Burns, Y. and A.V. Bhat, A.V. (1986). Primary anorexia nervosa in the male and female. *British Journal of Medical Psychology, 59, pp. 123–132.*

Cusack,J.,Deane,F.P., Wilson,C.J., & Ciarrochi,J. (2004). Who Influence Men to Go to Therapy? Reports from Men Attending Psychological Services. *International Journal for the Advancement of Counselling, 26,(3),pp.271-283.*

Dallesasse,S., Carney,J., Dagley,J., Kluck,A. (2011). *Reality Television and the Muscular Ideal*. (Doctoral Dissertation). Available from Auburn Theses and dissertations. (UMI: 10415/2481).

Dare,C., Eisler,I., Russell, G., Treasure,J., & Dodge, L. (2001). Psychological therapies for adults with anorexia nervosa; randomised controlled trial of out patients treatments. *British Journal of Psychiatry, 178, pp. 216-221.*

de la Rie, S., Noordenbos,G., Donker, M., & van Furth, E. (2008). The Quality of Treatment of Eating Disorders: A Comparison of the Therapists' and the Clients' Perspective. *International Journal of Eating Disorders,41,pp.307-317.*

Delucia-Waack,J. (1999). Supervision for Counselors Working with Eating Disorders Groups: Countertransference Issues Related to Body Image, Food, and Weight. *Journal of Counseling & Development,77, (4), pp. 379-88.*

Dennis, A.B., & Sansone, R.A.(1991). The clinical stages of treatment for the eating disorder patient with borderline personality disorder. In: C. Johnson, Editor, *Psychodynamic treatment of anorexia nervosa and bulimia*, Guilford Press, New York, pp. 128–164.

Eisenberg, M.E., & Neumark-Sztainer, D. (2010). Friends' dieting and disordered eating behaviours among adolescents five years later: Findings from Project EAT. *Journal of Adolescent Health.47,(1), pp. 67-73.*

Elliot,R., Fischer,C.T., Rennie,D.L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology,38,pp.215-229.*

Emmett,S.W.,Rabinor, J.R. (2007). The Therapists Voice: The Sated Starver. *Eating Disorders.15;(1) pp.81-84.*

Fairburn, C.G., Cooper, Z., Shafran, R. (2003). Cognitive Behavioural therapy for eating disorders: a “transdiagnostic” theory and treatment. *Behaviour Research and Therapy, Vol. 41,(5) pp.509-528.*

Fitcher,M.M., & Daser, C. (1987). Symptomatology, psychosexual development and gender identity in 42 anorexic males. *Psychological Medicine,17, pp. 409-418.*

Flahavan C. (2006). Detection, assessment and management of eating disorders; how involved are GPs? *Irish Journal of Psychological Medicine,* 23, *pp.* 96-99.

Foucault, M. (1984). *The History of Sexuality Vol. 3: The Care of the Self*. London: Penguin.

Franko,D.L., Keel,P.K.,(2006). Suicidality in eating disorders: Occurrence, correlates, and clinical implications. *Clinical Psychology Review,26, (6),pp.769-782.*

Freud, S. (1905). *Three Essays on Theory of Sexuality*. London: Hogarth.

Freud, S. (1910). The Future Prospects of Psycho-Analytic Therapy. *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* 6: Five Lectures on Psycho-Analysis, Leonardo da Vinci and Other Works, pp.139-152. Hogarth, London.

Freud, S., (1912). The Dynamics of Transference, in Strachey, J., (Ed.), (1978), *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* 7, Hogarth, London.

Freud, S., (1914), Remembering, Repeating and Working-Through (Further Recommendations on the Technique of Psychoanalysis II), in Strachey, J., (Ed.), (1978). *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* (pp. 43), Vol.7, London: Hogarth.

Freud, S. (1920). *A General Introduction to Psychoanalysis*. New York: Boni & Liveright.

Garner, D. M., & Garfinkel, P. E. (Eds.). (1997). *Handbook of treatment for eating disorders (2nd ed.).* New York, NY: The Guilford Press.

Giles,D.C.(2002). *Advanced Research Methods in Psychology.* New York:Routledge

Glaser, B. & Strauss, A. (1967). *The development of grounded theory.* Chicago: Alden.

Golan, M. (2009) The Eating Disorders Milieu. *World Psychiatry,8,3,pp.162–163.*

Goodsitt, A. (1985). Self psychology and the treatment of anorexia nervosa. In: D.M. Garner and P.E. Garfinkel, (Eds), *Handbook of psychotherapy for anorexia nervosa and bulimia*. New York: Guildford Press, pp. 55–82.

Gott, M., Galena,E., Hinchliff, S., & Elford, H.(2004). “Opening a can of worms”: GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice, 21, (5), pp.528-536*.

Gravener, J., Haedt, A., Heatherton, T.,& Keel, P. (2008). Gender and Age Differences in Associations between Peer Dieting and Drive for Thinness. *International Journal of Eating Disorders, 41,pp.57-63.*

Greenberg, S., Schoen, E. (2008). Males and Eating Disorders: Gender-Based Therapy for Eating Disorder Recovery. *Professional Psychology: Research and Practice, 39, (4), pp.464–471.*

Gusella, J. (2003). The Therapists Voice. *Eating Disorders, 11, pp.149–154.*

Guthrie,C. (1999). Nurses perception of sexuality relating to patient care. *Journal of Clinical Nursing, Vol. 8, (3), pp. 313-321.*

Hamburg,P. & Herzog, D. (1990). Supervising the therapy of clients with eating disorders. *American Journal of Psychotherapy, 44,(3),pp.369-80*.

Hay, P. J., Loukas, A., & Philpott, H. (2005). Prevalence and characteristics of men with eating disorders in primary care: How do they compare to women and what features may aid in identification? *Primary Care and Community Psychiatry, 10, pp. 1–6.*

Henwood,K.,& Pidgeon,N.F.(1992). Qualitative research and psychological theorising. *British Journal of Psychology, 83, pp.97-112.*

Henwood, K., Pidgeon, N., Camic, P., Rhodes, J., & Yardley, L. (Ed). (2003). *Qualitative research in psychology: Expanding perspectives in methodology and design.* Washington DC, USA, American Psychological Association.

Hepp, U., Milos, G. (2001). Gender Identity and eating disorders*. International Journal of Eating Disorders. Vol.32.(4) pp.473-478.*

Herrin,M., Matsumoto,N. (2007). *The Parents Guide to Eating Disorders Supporting Self-Esteem, Healthy Eating, & Positive Body Image at Home*. Carlsbad:Gürze Books.

Herzog,D.B., Norman,D.K., Gordon.C., & Pepose, M. (1984). Sexual conflict and eating disorders in 27 males. *American Journal of Psychiatry, Vol. 141, pp.989-990.*

Herzog,D.B., Newman,K.L., & Warshaw, M. (1991). Body image dissatisfaction in homosexual and heterosexual males. *Journal of Nervous & Mental Disease,179, pp. 356-359.*

Herzog,D.B. (1995). Psychodynamic psychotherapy for anorexia nervosa. In: C.G. Fairburn and G.T. Wilson, (Eds.), *Binge eating: Nature, assessment, and treatment*, (pp330-335). New York: Guilford Press.

Herzog,D.B.,Greenwood,D.N.,Dorer,D.J.,Flores,A.T.,Ekeblad,E.R,.Richards,A.,Blais, M,A.,Keller,M,B.(2000). Mortality in eating disorders: A descriptive study. *International Journal of Eating Disorders, 28, (1), pp 20-26.*

Hospers, H.J., Jansen, A. (2005). Why homosexuality is a risk factor for eating disorders in males. *Journal of Social and Clinical Psychology, 24, 8, pp. 1188-1201.*

Hudson, J.I., Hiripi, E., Pope Jr, G., & Kessler, R.C (2007). The Prevalence and Correlates of Eating Disorders in the National Comorbidity Survey Replication. *Biological Psychiatry*. *61,(3), pp. 348-358.*

Hughes, P.,Kerr,.I.,(2000). Transference and counter-transference in communication between doctor and patient. *Advances in Psychiatric Treatment, 6,pp.57-64.*

Humphrey, L.L. (1991). Object relations and the family system: An integrative approach to understanding and treating eating disorders. In: C. Johnson, (Ed),

Psychodynamic treatment of anorexia nervosa and bulimia, Guilford Press, New York (1991), pp. 321–353.

Jambekar, S.A., Masheb, R.M.,Grilo,C.M. (2003). Gender Differences in Shame in Patients with Binge-Eating Disorder. *Obesity Research,11, pp.571–577.*

Jung, C. (1933). *The Psychology of the Transference*, Princeton University Press.

Kapelovitz, L. H. (1987). *To Love and To Work: A Demonstration and Discussion of Psychotherapy*. New York: Grune & Stratton.

Kaplan,A.S.,Garfinkel,P.E.(1999). Difficulties in Treating Clients With Eating Disorders: A Review of Client and Clinician Variables. *Canadian Journal of Psychiatry,44,pp.665–670.*

Kelle, U. 2004: Computer-assisted analysis of qualitative data. In Flick, U., von Kardorff, E. and Steinke, I., editors, A companion to qualitative research. Sage, pp.276-283.

Kinsey, A.Pomeroy, W.B. & Martin,C.E.(1948). *Sexual Behaviour in the Human Male*. Philadelphia.Saunders.

Kinsey, A.,Pomeroy, W.B. & Martin,C.E.(1953). *Sexual Behaviour in the Human Female*. Saunders. Philadelphia.

Kearney-Cooke, A. (1991). The role of the therapist in the treatment of eating disorders: A feminist psychodynamic approach. In: C. Johnson, (Ed), *Psychodynamic treatment of anorexia nervosa and bulimia*, (pp.295-320) New York: Guilford Press.

Kulosh, N., Maymen,M.(1993). Gender limited determinants of transference and counter transference in Psychoanalytic Psychotherapy. *Psychoanalytic Inquiry, 13: pp.286-305.*

Le Grange, D., Lock, J. (2005). Dearth of psychological treatment studies for Anorexia Nervosa in Men. *International Journal of Eating Disorders, 37,(2), pp.79-91.*

Leon,S.C., Martinovich, Z., Lutz, W., & Lyons, J.S (2005). The effect of therapist experiences on therapeutic outcomes *Clinical Psychology and Psychotherapy, 12, pp.417–426.*

Levenkron, S. (1985). Structuring a nurturant/authoritative relationship with the anorexic patient. In: S.W. Emmett, (Ed), *Theory and treatment of anorexia nervosa and bulimia*, (pp.234-245). New York: Brunner/Mazel.

Lindblad, F., Lindberg,L., Hjern, A. (2006). Anorexia Nervosa in Young Men: A Cohort Study. *International Journal of Eating Disorders, 39, pp.662-666.*

Lock, J., le Grange,D. (2005). Family based treatment of eating disorders. *International Journal of Eating Disorders,Vol,37,S1,pp.64-67.*

Machado, P.P.P., Machado, B.C., Gonçalves, S., & Hoek, H.W. (2007). The prevalence of Eating Disorders Not Otherwise Specified. *The International Journal of Eating Disorders, 40,(3),pp.212-217.*

Mahalik,J., Good, G. Englar-Carlson, M. (2003). Masculinity Scripts, Presenting Concerns, and Help Seeking: Implications for Practice and Training. *Professional Psychology: Research and Practice, 34, 2, pp.123–131.*

Malan, D. (1999). *Individual Psychotherapy and the Science of Psychodynamics* (2nd edn). Oxford: Butterworth-Heinemann.

Malson, H., Finn, D., Treasure, J., Clarke. S and Anderson, G.(2004). Constructing 'The Eating Disordered Client': A Discourse Analysis of Accounts of Treatment Experiences. *Journal of Community & Applied Social Psychology, 14, pp.473–489.*

Malson, H. Clarke, S.& Finn,M.(2008). I don't think that's normal; A reflection on accounts of experiences of treatment for eating disorders. *Feminism & Psychology.18, 3, pp. 417-424.*

Masters, W., & Johnson, V. (1970). *Human Sexual Response.* Boston: Little Brown & Co.

Matocha, L.K., & Waterhouse, J.K.(1993). Current nursing practice related to sexuality. *Research in Nursing and Health, 16, pp.371-378.*

Matthewson, K., & Nishawala, M. (2009). Review of The invisible man. A self-help guide for men with eating disorders, compulsive exercise, and bigorexia. *Journal of Child and Adolescent Psychopharmacology, 19, (2), pp. 213-214.*

Matz, J., & Frankel, E. (2005). Attitudes toward disordered eating and weight: Important considerations for therapists and health professionals. *Health at Every Size, 19, (1), pp19-30*.

McCabe, M.P., Ricciardelli,L.A. & Holt, K.(2010). Are there different socio-cultural influences on body image and body change strategies for overweight adolescent boys and girls? *Eating Behaviours, 11, (3), pp 156-163.*

McCreary, D. R., & Sasse, D. K. (2000). An exploration of the drive for muscularity in adolescent boys and girls. *Journal of American College Health, 48, pp.* 297–304.

Magnan,M.A., Reynolds, K.E., & Galvin,E.A. (2005). Barriers to addressing patient sexuality in nursing practice. *Medsurg Nurs,14,5, pp.282-9.*

Mitchell, K. & Mazzeo, S. (2005). Mediators of the association between abuse and disordered eating in undergraduate men. *Eating Behaviors,6,4, pp. 318-327.*

Mogul,K. (1982). Overview: The sex of the therapist. *American Journal of Psychiatry,139, pp.1-11.*

Mond, J.M.,Owen, C.,Hay,P.J., Rodgers,B., Beumont,P.J.V. (2005). Assessing quality of life in eating disorder clients. *Quality of Life Research.14, 1, pp. 171-178.*

Morgan, J. (2008). *Invisible Man: A Self-help Guide for Men With Eating Disorders, Compulsive Exercise and Bigorexia*. Hove, East Sussex, New York Taylor & Francis Routledge.

Olivardia, R. (2007). *Body Image and Muscularity. Textbook of Men's Health*. New York: American Psychiatric Publishers.

Openshaw,C.,Waller,G., & Sperlinger,D. (2004). Group cognitive-behaviour therapy for bulimia nervosa: Statistical versus clinical significance of changes in symptoms across treatment. *International Journal of Eating Disorders,36,pp.363-375.*

Pikus,C. Heavey,C.(1996). Client Preferences for Therapist Gender. *Journal of College Student Psychotherapy. 10, 4, pp.35-43.*

Ponterotto, J.G.,& Grieger, I.(1999). Merging qualitative and quantitative perspectives in research identity. In M.Kopala & L.A. Suzuki(Eds), *Using qualitative methods in psychology* (pp.49-62).London:Sage Publications.

Raevuori, A., Keski-Rahkonen,A., Hoek,H., Sihvola, E., Rissanen, A., & Kaprio, J. (2008). Lifetime Anorexia Nervosa in Young Men in the Community: Five Cases and Their Co-Twins. *International Journal of Eating Disorders, 41,(8), pp. 758-761.*

Ramjan,L.M. (2004). Nurses and the 'therapeutic relationship': caring for adolescents with anorexia nervosa. *Journal of Advanced Nursing, 45, 5, pp. 495–503.*

Redman, L.M. Loucks, A.B. (2005). Menstrual Disorders in Athletes. *Sports Medicine. Vol.35,(9), pp. 747-755.*

Reichborn-Kjennued,T.,Bulik,C.M.,Sullivan,P.F.,Tombs,K., & Harris,J.R. (2004). Psychiatric and Medical Symptoms in Binge Eating in the Absence of Compensatory Behaviors. *Obesity Research, 12, pp.1445–1454.*

Robin, A.L., Siegel,P. Bedway, M., Gilroy,M. (1996). Therapy for adolescent anorexia nervosa: Addressing cognitions, feelings, and the family's role. In: Hibbs,E.D, & . Jensen,P.S. (Eds), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice*,(pp239-259). American Psychological Association, Washington, DC.

Robinson, K., Mountford,V.A., Sperlinger,D. (2012). Being Men with Eating Disorders: Perspectives of Male Eating Disorder Service-Users*. Journal of Health Psychology,17, 4, pp.1461-7277.*

Royal College of General Practitioners (2011). *Increase in men suffering eating disorders*. Statement published on 14TH July. Retrieved from http://www.rcgp.org.uk

Russell, C.J.,& Keel, P.K. (2002).Homosexuality as a specific risk factor for eating disorders in men. *International Journal of Eating Disorders, 31, pp.* 300–306.

Ryan, V. Malson, H.Clarke, S.Anderson, G. Kohn, M.(2006). Discursive constructions of eating disorders nursing: an analysis of nurses' accounts of nursing eating disorder clients. *European Eating Disorders Review. 14, (2), pp.125-135.*

Sallas A.A.(1995). Treatment of eating disorders: Winning the war without having to do battle. *Journal of Psychiatric Research,19, 2-3, pp. 445-448.*

Satir,D.,Thompson-Brenner,H., Boisseau, C., Crisafulli, M. (2009). Countertransference reactions to adolescents with *eating disorders*: Relationships to clinician and client factors. *International Journal of Eating Disorders. 42,(6), pp. 511-521.*

Sharp, C., Clark, S., Dunan, J.. Blackwood, D., Shapiro, C. (1994). Clinical presentation of anorexia nervosa in males: 24 new cases. *International Journal of Eating Disorders.15, 2, pp. 125–134.*

Shipton,G. (2004). *Working with Eating Disorders a Psychoanalytic Approach*. Palgrave & Macmillan.

Shisslak, C. M., Gray, N. & Crago, M. (1989). Health care professionals' reactions to working with eating disorder patients. *International Journal of Eating Disorders*, *8, pp.689–694.*

Siegel,J.H., Hardoff,D., Golden,N.H. & Shenker,R.I. (1995). Medical complications in male adolescents with Anorexia Nervosa. *Journal of Adolescent Health, 16, (6*), *pp. 448-453.*

Siever, M.D. (1994). Sexual orientation and gender as factors in socio-culturally acquired vulnerability to body dissatisfaction and eating disorders. *Journal of Consulting & Clinical Psychology, 62, pp. 252-260.*

Silberstein, L.R., Mishkind, M.E., Striegel-Moore, R.H., & Timko, C. (1989) Men and their bodies: A comparison of homosexual and heterosexual men. *Psychosomatic Medicine,51, pp.337-346.*

Smart, R. (2006). A man with a "woman's problem": Male gender and eating disorders. In M. Englar-Carlson & M. Stevens (Eds.), *In the room with men: A casebook of therapeutic change* (pp. 319–338). Washington, DC, US: American Psychological Association.

Smith, J. A., Flowers, P. & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and condition. In L. Yardley (Ed), *Material discourses of health and condition*. (pp.72-89).London: Routledge.

Smith J.A., Braunack-Mayer A., Wittert,G. (2006). What do we know about men's helpseeking and health service use? *The Medical Journal for Australia, 184, (2), pp. 81–83.*

Smolak, L., Murnen,S. & Thompson, J.K.(2005). Socio-cultural influences and muscle building in adolescent boys.*Psychology of Men & Masculinity, 6,pp.227-239.*

Snell,L., Crowe,M., Jordan,J.(2009). Maintaining a therapeutic connection: nursing in an inpatient eating disorder unit. *Journal of Clinical Nursing, 19, pp.351–358.*

Soban,C. (2006). What about the boys?: Addressing issues of masculinity within male anorexia nervosa in a feminist therapeutic environment. *International Journal of Men's Health, 5,(3), pp.251-267.*

Steiger, H. (1989). Anorexia nervosa and bulimia in males: Lessons from a low-risk population. *Canadian Journal of Psychiatry, 34, pp.419–424*.

Sterling, J. W., & Segal, J. D. (1985). Anorexia nervosa in males: A critical review. *International Journal of Eating Disorders, 4, 559-572.*

Strauss,A.L., & Corbin,J,M. (1990). *Basics of qualitative research; Techniques and procedures for developing grounded theory.* Thousand Oaks,CA.: Sage Publications.

Striegel-Moore,R. & Bulik, C. (2007). Risk factors for eating disorders, *American Psychologist, 62,(3), pp. 181–198.*

Streigel-Moore, R., Rossello, F., Perrin, N,. DeBar, L., May, A., Kraemer, H. (2009). Gender differences in the prevalence of eating disorder symptoms. *International Journal of Eating Disorders, 42,(5),pp. 471-474.*

Surgenor,L.J., Fear,J.L. (1998). Eating Disorder in a Transgendered Patient: A Case Report. *International Journal of Eating Disorders. Vol. 24,(4). pp.449-452.*

Swan,S. Andrews,B.(2003). The relationship between shame, eating disorders and disclosure in treatment. *British Journal of Clinical Psychology, Vol. 42,pp.367-378.*

Tanney, M. Birk, J. (1976). Women Counsellors for Women Clients? A Review of the Research. *The Counselling Psychologist,6,pp.28-32.*

Warren, C., Crowley,M.E., Olivardia,R.,Schoen, A. (2009). Treating Clients with Eating Disorders: An Examination of Treatment Providers' Experiences. *Eating Disorders*, *17,pp.27–45.*

Weltzin,T., Weisensel,N., Franczyk,D., Burnett, K.,Klitz,C., Bean,P. (2005). Eating disorders in men: update. *The Journal of Men's Health & Gender, 2, (2), pp.186-193.*

Werner-Wilson, R. J., Murphy, M. Fitzharris, J.(2004). Does therapist experience influence interruptions of women clients? *Journal of Feminist Family Therapy.16, (1), pp. 39-49.*

Wichstrøm,L. (2006). Sexual Orientation as a Risk Factor for Bulimic Symptoms. *International Journal of Eating Disorders. (39), pp. 448-453.*

Williams M, Leichner P.(2006). More training needed in eating disorders: a time cohort comparison study of Canadian psychiatry residents. *Eating Disorders*,*14,pp.323–334.*

Williamson,I., & Hartley,P. (1988). British research into the increased vulnerability of young gay men to eating disturbance and body dissatisfaction. *European Eating Disorders Review, 6, 160-170.*

Winston, A. (2006). The Oedipus complex in anorexia nervosa. *Psychoanalytic Psychotherapy, 20, (1),pp. 1–15.*

Woodside, D., Garfinkel, P., Lin, E., Goering,P., Kaplan, A., Goldbloom,D., Kennedy,S. (2001). Comparisons of Men With Full or Partial Eating Disorders, Men Without Eating Disorders, and Women With Eating Disorders in the Community. *American Journal of Psychiatry, 158,pp.570-574.*

Yelland, C., Tiggemann, M. (2003). Muscularity and the gay ideal: body dissatisfaction and disordered eating in homosexual me. *Eating Behaviours, 4,2,pp.107-116.*

Zeeck. A, & Hartmann. A (2005). Relating therapeutic process to outcome: are there predictors for the short-term course in anorexic clients? *European Eating Disorders Review,13, (4), pp. 245-254.*

Zerbe,K.J.(1998).Knowable secrets: Transference and countertransference manifestations in eating disordered patients. In W.Vandereycken & P.J.Beumont (Eds),*Treating eating disorders: ethical, legal and personal issues*(pp.30-55).New York: New York University Press.

Zerbe, K. J. (2008). *Integrated treatment of eating disorders-Beyond the body betrayed.* New York,NY:W.W.Norton & Company,Inc.

Zunino,N. Agoos,E.,Davis , W.N. (1991).The impact of therapist gender on the treatment of bulimic women. *International Journal of Eating Disorders.10,3,pp.253-263.*

Chapter Three

Reflections of a Male Trainee Clinical Psychologist Working with Female Eating Disorder Clients.

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(See appendix A for notes to contributors)

3.1 Introduction

This paper provides a reflective account of my experiences of being a male Trainee Clinical Psychologist working in an acute eating disorder service with female clients.

I will discuss the demanding nature of working clinically in eating disorder settings and the impact it has on me, what it is that may have drawn me to work in this clinical speciality. Finally, I will reflect upon significance of my gender in relation to my clinical experiences. In order to illustrate this, I will use a brief case example of my clinical work with a female client. Wherever applicable, I will attempt to relate my experiences and reflections to the research in this field.

3.2 Demanding nature of working with eating disorder clients

Prior to beginning my work in eating disorders, I was aware of literature suggesting that eating disorder settings are extremely challenging for clinicians (Zerbe, 2008). Due to the complex nature of eating disorder clients, high rates of stress and frustration are commonly experienced by clinicians (Warren, Crowley, Olivardia &

Schoen, 2009, Ramjan, 2004; Ryan, Malson, Clarke & Anderson, 2006, Kaplan & Garfinkel, 1999). These experiences often lead to clinicians' reluctance to work eating disorders. Brotman, Stren and Herzog (1984) Burkett & Schramm, (1995).

3.3 What drew me to work in eating disorders?

As I was aware of the demanding nature of working clinically with eating disorders, I was interested in reflecting on what drew me to choose to work in this field. Initially, I thought I was drawn to work in this setting as it provided me with the opportunity to work psychotherapeutically with complex cases using both Psychodynamic and Systemic perspectives, something which appealed to me. However, on reflection, the opportunity to using both Psychodynamic and Systemic perspectives is not something that is unique to eating disorder field. I therefore began to reflect on my beliefs about food and body shape and how this may have influenced my decision to work in this setting.

Bunnell (2009) suggests that a 'therapist's personal experiences of factors including eating patterns, weight concerns, can come into play during the course of eating disorder treatment' (page 82). McVoy (1998) also discussed the importance of using 'information about my family and my own memories to recognise patterns of male interaction with females that shaped my scripted responses to women' (page 92). I

therefore attempted to consider the impact of these factors on my decision to work in this setting.

I am part of a family that was always very interested in sports and placed a high level of importance on being active and maintaining a balanced diet at all times. I recall that my father was very critical of those who were overweight. He would explicitly state that being overweight was a sign of laziness, indulgence and weakness. This was in combination with my mother's regular attempts to diet in order to lose weight, with varying degrees of success. The behaviours and beliefs of my parents shaped the environment in which I grew up; an environment that led to an unconscious fear of becoming fat for fear of rejection from my father, resulting in my increased awareness of food and body shape from a young age.

My focus on food and body shape from a young age led to me developing aspects of disordered eating pathology in later life, i.e. the idealisation of thinness, body dissatisfaction and regular dieting (Stice, 2002). Interestingly, evidence suggests that aspects of disordered eating pathology or even clinical eating disorder histories are very common in staff working in eating disorder services, (Rance, Moller & Douglas, 2010). It has been informally estimated that between one in three staff members in eating disorder services have eating disorder histories, (Barbarich, 2002; Johnston, Smethurst & Gowers, 2005). This process of reflection has increased my insight into the idea that my beliefs about food, exercise and body shape formed from an early age may have played a significant factor in my desire to work clinically in eating disorders settings.

Another factor that may have drawn me to eating disorder settings could have been the opportunity to be noticed. For example, on my eating disorder placement, male members of staff and male eating disorder clients were very rare. When male clients did access the service, this raised levels of interest and curiosity from staff about the men who accessed services. I wonder if the same interest and curiosity are raised when male members of staff choose to work in these predominantly female settings. On reflection, I wondered if there was something attractive to me about being a man in a female world, about being different and being noticed.

Further reflection on this made me consider my relationships with females in my personal life. Perhaps, as a result of my distant relationships with close female family members, it is important for me to work in a predominantly female world and be noticed and acknowledged. Another possibility may be that, as a trainee in the final year of Clinical Psychology Doctoral training, I was feeling under pressure to stand out and be recognised in order to increase future possibilities of employment opportunities.

3.4 Impact on therapists of working in eating disorders

Research suggests that working in eating disorders increases therapists' awareness of their own body and physical appearance (Shisslak, Gray & Crago, 1989). Warren, Crowley, Olivardia & Schoen (2009) found that therapists can experience changes in

eating habits, views of their body image and appearance, as well as a heightened awareness of food and physical health when working with eating disordered clients. Lowell & Meader (2005) discuss how a 'client's distorted projection of the therapist's body or her own can impact the therapist's own body image', (page243). Consequently, it has been suggested that therapists in eating disorder settings would benefit from examining their own thoughts and feelings about their bodies, appearance and food (Delucia-Waack, 1999).

As part of this paper I have therefore begun to examine my thoughts and feelings about my body and food. Since beginning to work clinically with eating disorder clients, I became aware that my relationship with food had begun to change. For example, I was aware that I was becoming more restricted about my food choices. I began checking the packages of foods for information about calories and fat content which was something I had not felt inclined to do previously. I was also aware that my level of exercise increased significantly whilst working in this setting.

I feel this change occurred as a result of being in an environment where there is day to day clinical discussion of client weight, food choices, calories and mealtime behaviour. On reflection, I feel this meant I became somewhat hyper-vigilant regarding my own food choices.

As well as the physical impact of working in this setting, I have also reflected on the psychological impact of working with such a demanding client group. Bunnell (2009) suggested that 'in contrast to psychotherapy with other kinds of patients, eating

disorder therapists may feel held, or in fact hold themselves, to particularly high, exacting performance standards' (page 84). On reflection, I feel I can relate to this. For example, in previous Clinical Psychology placements that lasted six months I felt there was an adequate amount of time to conduct a small piece of clinical work that would hopefully result in some form of positive outcome for the client. However, with the complexity of the clients in an eating disorder setting, a six month placement felt a very limited amount of time, therefore a positive clinical outcome was more unlikely. Interestingly though, instead of this subsequently lowering my clinical expectations, I actually felt under more pressure to obtain a positive clinical outcome as a result. Evidence suggests a strong relationship between eating disorders and perfectionism, (Bardone-Cone, Wonderlich, Frost, Bulik, Mitchell, Uppala, Upplas, Siomnich, 2007). I reflected in supervision that as well as the clients I was working with often demonstrating perfectionism in all aspects of their lives, I was also displaying aspects of perfectionism as something that I been experiencing through the process of transference (Bunnell, 2009) from my clients. Related to this, I was aware that whilst working with female clients, I did not receive comments regarding my body shape, which is commonly reported by female therapists working with female clients (Warren, Crowley, Olivardia & Schoen, 2009). I wonder if female clients were less focused on my physical appearance and more focused on my perceived lack of competency and understanding of eating disorders as a man. This was then experienced by myself through a transference reaction leading to my experiencing the need for perfection in my clinical work.

3.5 Impact of Therapist Gender

Often on Clinical Psychology placements, the majority of the psychologists in psychology services are female. As a man, I am therefore used to being in the minority on clinical placements. However, in eating disorders, due to the rarity of both male clients and fellow male therapists, my gender was even more apparent.

I was also aware that my gender may have been a barrier in my clinical work, as research suggests that female therapists are in a better position to treat female eating disorders clients (Bilker, 1993, Burkett & Schramm, 1995, Stockwell & Dolan,1994, Zunino, Argos & Davis, 1991). Research attributes the advantage to female therapists' experiencing aspects of womanhood related to the development of eating problems, e.g. the biological experience of being a woman, over concerns about weight, sexuality, roles as a woman, importance of client's concerns with body image, (Orlinksy & Howard,1976).

My lack of clinical experience in eating disorders prior to beginning my placement exacerbated my anxiety of being in a room with a woman with what society often terms a 'female' problem. For example, I was aware that just as female eating disorder clients are often uncomfortable, resistant and occasionally avoidant of being weighed, I was uncomfortable weighing female clients. When I reflected on this, I felt that this may have been related to the social construct that it was rude for a man to ask women about their weight. It was an interesting process, moving from a personal position of 'weight being something that you never discuss with females' to a professional position where weight is the primary focus.

As my time progressed on my eating disorder placement, I became more comfortable focusing on the weight of my female clients. However, I was conscious that at times when I was unsure how to deal with difficult emotions and feelings in the room, I would then begin to focus on the client's weight, at perhaps the expense of the client's feelings and needs. I wonder if just sitting with this awkwardness was too difficult for me and it was a relief for me to return to discussion of weight as it felt a safer topic. I also wondered if this was related to my gender; is it easier as a man in this female environment to focus on figures and measurement rather than feelings and thoughts? My need to have a measurement, a figure to leave the session with, was perhaps a comfort to me in this clinical environment. However, by doing this, I may have missed important clinical information that could help improve engagement with the client.

In conducting my research in eating disorder settings I was able to speak to both male and female therapists about their experiences of working with eating disorder clients. Therapists of both genders gave similar examples, where they focused on one aspect with the client in an attempt to avoid more difficult clinical topics. This was reassuring to me as a trainee who often doubted his clinical skills. I was also very interested in how common this avoidance from both therapists and clients appeared to be in eating disorder settings and what this may say about the difficulty of working with clients in this area.

3.6 Case Example

In order to explore these ideas further, I will discuss a clinical example of my work with a female client from my eating disorder placement. The client had a long history of anorexic type disordered eating, she had sporadic contact with the eating disorder service, having difficulty engaging with the service for long enough in order to bring about significant change. I was asked to see this client in order to conduct further assessments and to begin to engage her with the service. Due to the severity of her eating disorder and her isolation at home it was hoped that she may accept an invitation to become an inpatient on the acute eating disorder ward.

Following the initial sessions with this client, I was very aware that I was being left with a great amount of sadness, depression and pity during sessions and consequently would spend a lot of time thinking about this client in between sessions. I used supervision to explore this, as suggested by Kopp, (1994) for male therapists working in eating disorder services, I had a female supervisor. Kopp (1994) wrote 'this fairly balanced approach allows the therapist to benefit from understanding his own emotions, thoughts and behaviours in a way that transcends socialised roles' (page 69). Having a female supervisor when working with this client group helped me separate what may have been a client's reaction to my gender, from my own reactions. As well as individual supervision, I also attended weekly group supervision with fellow staff members, where clinical cases would be discussed predominantly from a psychodynamic perspective.

In group supervision I was surprised to hear that fellow staff members who also had contact with this client, found her frustrating and annoying as a result of her avoidance of services. It was interesting that my experience of being with this client had been so different to those other team members' experiences. I began to think more about why this may have been the case. When considering this, I reflected upon the importance of the Oedipal Complex (Freud, 1956) in the treatment of female eating disorder clients, Lawrence (2001) refers to the 'enmeshment' between mother and daughter that frequently occurs. Due to the complexity of eating disorder patients, they are often seen by a number of professionals. For example, the Oedipal split between mother and father is often acted out in relationships with professionals, with often one professional being idealized while the other is denigrated and excluded, (Bruch, 1978, Winston, 2006). This was the case with this client who was described as having a warm and close relationship with a nurse on the ward and yet a distant and difficult relationship with the Psychiatrist.

In particular, I was curious as to why the client was placing sadness, depression and helplessness with me? Did this represent a re-enactment of another important relationship? It was suggested in group supervision, that her son, who she no longer had contact with, and I, were approximately the same age; perhaps I was feeling the emotions that she wanted her son to feel e.g. empathy, sadness, understanding?

Following discussions in individual and group supervision, I became more reflective of the client's motives for projecting (Holmes, 1968) these feelings onto me. I now

wonder if this was an unconscious way for the client to disarm me from being direct with her with regard to her avoidance of engaging with the inpatient programme?

With this in mind, in later sessions I became more focused on assessment and her preparation for inpatient admission. The result of this was that the atmosphere in the sessions changed. It felt very awkward and uncomfortable to switch the sessions from her projecting sadness into a more focused session, where I would ask her to step on the scales and talk about food and her eating. Interestingly, when our sessions together became more focused on assessment and preparation for inpatient admission, she began to withdraw from all contact with the eating disorder service.

Bunnell (2009) writes that eating disorder patients are often resistant about giving up their disordered eating because 'it almost feels like losing a very significant relationship' (page 82). This seems particularly relevant to this client, as she no longer had contact with any of her family. As healthcare professionals, we were asking her to give up the only thing she was attached to that gave her comfort, something that had been an integral part of herself. I also reflected that my patient's poor engagement could also be thought about in terms of the Oedipal complex. For example, as a result of the intensity of the Oedipal relationship, the patient may have been terrified of fusion with me as the therapist; she may have felt that she exists to only gratify the desires of one parent. This could have resulted in defending against my attempts to engage with her by sabotaging sessions (Winston, 2006) with her lack of engagement and eventual non-attendance.

3.7 Conclusion

McVoy (1998) suggested that male therapists working in eating disorder settings need to increase awareness of their behaviours and reflections of their contact with female patients in order to improve their clinical interventions. For me, this reflective process has involved examining my childhood experiences, my desire to work in eating disorder settings.

The demanding nature of eating disorder environments had both a psychological and physical impact upon me, i.e. the increased pressure I felt under for outcomes and how my relationship with food changed. Due to the complex nature of working with female eating disorder clients, it has been very thought provoking and highlighted the importance of gender and counter-transference in my future clinical interventions.

The experience of being a male therapist and working with female clients in a predominantly female clinical environment has provided me with the opportunity to explore the impact of gender on the therapeutic relationship. I feel that for some female clients, my gender may have hindered initial engagement and challenged or triggered a reaction that may have led to strong transference reactions. Reflecting on the psychodynamic processes experienced when working with female eating disorder clients has highlighted the importance of gender on therapeutic process with clients in all clinical specialties not just eating disorders.

3.8 References

Adshead,G. (1998). Psychiatric staff as attachment figures; understanding management problems in psychiatric services in the light of attachment theory. *British Journal of Psychiatry, 172, pp.64-69.*

Barbarich, N.C. (2002). Lifetime prevalence of eating disorders among professionals in the field. *Eating Disorders, 10, pp.305-312.*

Bolton, G. (2003). Lift the box lid: reflective writing for professional development. *Clinical Psychology, 27, pp. 39-41.*

Bowlby, J. (1988). *A secure base: Clinical Applications of Attachment Theory.* London. Routledge.

Braun, D. L., Sunday, S. R., Huang, A., & Halmi, K. (1994). Psychiatric comorbidity in patients with eating disorders. *Psychological Medicine, 24, pp. 859-867.*

Brotman, A.W., Stern, T.A., & Herzog, D.B. (1984). Emotional reactions of house officers to patients with anorexia nervosa, diabetes, and obesity. *International Journal of Eating Disorders, 3, (4), pp. 71-77.*

Bruch, H. (1974). *Learning psychotherapy: Rationale and ground rules.* Cambridge: Harvard University Press.

Bruch, H. (1978). The Golden Cage (Cambridge, MA: Harvard University Press)

Bunnell, D. (2009). Countertransference in the psychotherapy of patients with eating disorders. pp. 79-93. In Maine,M.,Davis,W.M.,Shure, J.(eds). *Effective Clinical Practice in the Treatment of Eating Disorders*. Routledge, Taylor & Francis Group.

Bardone-Cone,A.M., Wonderlich,S.A., Frost,R.O., Bulik, C.A., Mitchell,J.E., Uppala,S., Siomnich,H. (2006). Perfectionism and eating disorders: Current status and future directions. *Clinical Psychology Review. 27,3, pp.384-405.*

Casement, P. (1985). *'On learning from the patient'.* Routledge.

Delucia-Waak, J.L (1999). Supervision for Counselors Working with Eating Disorders Groups: Countertransference Issues Related to Body Image, Food, and Weight. Journal of Counselling & Development, 77,(4) p379-88

Franko,D.L., & Rolfe,S. (1996). Countertransference in the treatment of patients with eating disorders. *Psychiatry, 59,(1),pp.108-116.*

Freud, S. (1956). *On Sexuality*. Penguin Books Ltd.

Henwood, K. L., & Pidgeon, N. F. (1992). Qualitative research and psychological theorising. *British Journal of Psychology, 83, pp.97–111.*

Holmes.D.S. (1968). Dimensions of Projection. *Psychological Bulletin, 69,(4), pp. 248-268.*

Jobe, R.,Herbert,K., Knibbs,J., & Phillips,W. (2012). Therapists' experiences of working with men with eating disorders. Unpublished Doctoral Thesis in Clinical Psychology. Submitted in partial fulfilment for Doctorate in Clinical Psychology for Coventry University & the University of Warwick, June 2012.

Johnstone,C.,Smethurst, N., & Gowers, S.(2005). Should people with a history of an eating disorder work as eating disorder therapists. *European Eating Disorder Review, 13, pp.301-310.*

Kaplan,A.S., & Garfinkel,P.E.(1999). Difficulties in Treating Patients With Eating Disorders: A Review of Patient and Clinician Variables. *Canadian Journal of Psychiatry, 44.pp.665–670.*

Kopp, W. (1994). Can women with eating disorders benefit from a male therapist?' In B, Dolan, and I, Gitzinger. (Eds) *Why women? Gender issues and eating disorders (pp.65-71),* London: Athlone.

Lawrence, M. (2001). Loving them to death: the anorexic and her objects. *International Journal of Psycho-Analysis, 82, pp.43–54.*

Lowell, M.A., Meader, L.L.(2005). My body, your body: Speaking the unspoken between the thin therapist and the eating disordered patient. *Clinical Social Work Journal,33,(3),pp.241-257.*

McVoy,J. (1998). Personal experiences of male therapist. pp.80-105. In Vanderycken,W.,Beumont,P.J.V. *Treating Eating Disorders, Ethical, Legal and Personal Issues*. The Athlone Press.

Orlinsky,D.E., & Howard,K.I. (1976). The effects of sex of therapist on the therapeutic experiences of women. *Psychotherapy: Theory, Research & Practice, 13,(1), pp.82-88.*

Rance, N.M., Moller, N.P., & Douglas, B.A. (2010). Eating disorder counsellors with eating disorder histories: A story of being “normal”. *Eating Disorders: The Journal of Treatment & Prevention, 18, 5, pp.377-392.*

Shipton, G. (2004). *Working with eating disorders.* Basingstoke,UK:Palgrave Macmillian.

Stice,E. (2002). Risk and Maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin, 128,5,pp.825-848.*

Stockwell, R. & Dolan, B. (1994).*Women therapists for women patients?*’In Dolan, B. & Gitzinger, I. (Eds) *Why women? Gender issues and eating disorders (pp.57-64),*London:Athlone.

Warren, C.S., Crowley, M.E., Olivardia, R. & Schoen, A.(2009). Treating clients with eating disorders: An examination of treatment providers' experiences. *Eating Disorders,17,(1),pp.27-45.*

Winnicott, D. W. (1991). Playing and Reality (London: Routledge)

Winston, A.P.(2006). The Oedipus Complex in Anorexia Nervosa. *Psychoanalytic Psychotherapy. 20,1, pp.1-15.*

Zerbe, K. (2008). *Integrated treatment of eating disorders-Beyond the body betrayed.* New York,NY:W.W.Norton & Company,Inc.

Zunino, N., Agoos, E., & Davis, W.N. (1991). The impact of therapist gender on the treatment of bulimic women. *International Journal of Eating Disorders.10,(3), pp. 253-263.*