THE HIDDEN FACES OF EATING DISORDERS AND BODY IMAGE

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CHAPTER 3

Men and Muscles: The Increasing Objectification of the Male Body

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Chapter Objectives:

(1) Describe the evolution of the idealized male body image over the past three decades.

(2) Introduce risk factors that are salient in the development of disordered eating among men.

(3) Discuss issues and obstacles related to men receiving treatment for body image concerns and eating disturbances.

(4) Identify directions for future research in body image and disordered eating among males.

Case Example

Sam is a 30-year old, Caucasian male who, by outward appearances, is a successful young professional. He maintains a career, has a set of friends, is financially stable, and is seen as attractive by others. However, he does not see himself that way and he believes that his body should be bigger and stronger. Sam did not participate in organized sports while in high school or college, yet he stayed physically fit by engaging in aerobic activities, such as running and biking. As a result, his body fat percentage was pretty low, but his build remained slight. Once he graduated from college, he began to have difficulty meeting women and, when he did, was not successful in maintaining the relationship. He became convinced that his lack of success in relationships was due to how he looked, specifically that his body was not sufficiently attractive to women. He believed that women were attracted to a lean, muscular man...the type that he would see on the pages and covers of magazines. As a result, he became intensely focused on his appearance and took steps to change the size and shape of his body. He began to read health and fitness magazines to learn more about working out and then joined a health club where he spent many hours each week, focusing primarily on lifting weights to increase his size and muscularity. When these efforts did not give him the results he wanted, he started to take nutritional supplements (e.g., creatine). As his focus on his body and workouts grew, he became less interested in his friends, often breaking preplanned social engagements. His work also suffered because he was spending less time there and, when he was present, he was often distracted by thoughts about how dissatisfied he was with his appearance and how he needed to work out more to obtain what he saw as his body ideal. Although he always had been a confident person, believing that he was smart and capable at his job and a good friend, he now was so focused on his appearance that his self-esteem and confidence were defined almost solely by the size and shape of his body. He thought that his life would be better only after he had achieved his body ideal.

Although studies addressing body image and eating disturbances historically have focused on girls and women, in the past two decades researchers also have turned their attention to men and how the sociocultural environment has increased their risk of developing these disturbances. As the sociocultural environment (e.g., media images) evolved during this time and increasingly put men's bodies on display, making them more "objects of gaze" than individuals of accomplishment, men have become more focused on their bodies and more concerned when they do not reach the socially prescribed ideal. In fact, during the last three decades, there has been a clear shift in

the male body ideal to a hyper-muscular, hyper-lean physique that is now ubiquitous in most Western societies (Furnham, Badmin, & Sneade, 2002). With this societal shift has come an increase in body dissatisfaction among men, particularly with the abdomen and chest, which rises nearly to the levels reported by women (Garner, 1997). As illustrated in the case example of Sam, men now are internalizing societal expectations about how they should look, feeling worse about themselves and their bodies, and taking extreme steps to alter their bodies to achieve this ideal. Unfortunately, like women, these men are experiencing many of the same negative psychological outcomes associated with having a poor body image and a singularly defined self-concept, including clinical and subclinical eating disturbances, affective disorders (i.e., depression and anxiety), substance abuse, and muscle dysmorphia (MD) (Hudson, Hiripi, Pope, & Kessler, 2007; Olivardia, Pope, Borowiecki, & Cohane, 2004; Woodside et al., 2001).

Prevalence and Characteristics of Body Image and Eating Disturbances

Body image and eating disturbances are no longer just a woman's problem and, although at lower rates than found among girls and women, boys and men also suffer from anorexia nervosa (AN), bulimia nervosa (BN), eating disorders not otherwise specified (ED-NOS), subclinical disordered eating, and body image concerns. In fact, men and women with eating disorders are similar to one another in terms of clinical and associated features (e.g., Hay, Loukas, & Philpott, 2005; Woodside et al., 2001), though some key differences do exist, such as age of onset (Carlat & Camargo, 1991; Carlat, Camargo, & Herzog, 1997), that differentiate the two groups. In the sections that follow, we provide an overview of current prevalence rates and characteristics associated with body image and eating disturbances among men. Where applicable and where data exist, these rates and characteristics are presented in comparison to women or among different subgroups of men.

Clinical Disorders

Over the last 10 years, numerous prevalence studies have been conducted, using community and population-based samples as well as those of convenience and focusing on adolescents as well as adults (Currin, Schmidt, Treasure, & Jick, 2005; Hay et al., 2005; Hoek, 2006; Hudson et al., 2007; Kinzl, Traweger, Trefalt, Mangweth, & Biebl, 1999; Kjelsås, Bjørnstrøm, & Götestam, 2004; McNulty, 1997; Schuckit, Tipp, Anthenelli, Bucholz, Hesselbrock, & Nurnberger, 1996; Woodside et al., 2001). Lifetime prevalence rates from the studies that have used more rigorous diagnostic procedures (e.g., interviews) have been relatively consistent, ranging 0.0% to 0.3% for AN, 0.13% to 0.96% for BN, 0.8% to 2.0% for Binge Eating Disorder (BED), and 5.0% to 9.4% for EDNOS (not including BED); prevalence rates from studies using

only self-report questionnaires have been higher: 2.5% for AN, 6.8% for BN, and 40.8% for EDNOS (McNulty). Incidence rates, expressed in number of cases per 100,000 in the population, have ranged from 0.3 to 0.7 for AN, and from 0.13 to 0.7 for BN. In comparison, the relative risk of women having a clinical eating disorder is much higher than for men: 3 to 12 times higher for AN, 3 to 18 times for BN, and 1.5 for BED (Currin et al.; Hudson et al.; Woodside et al.). Of the clinical disorders, BED and EDNOS are the most common in the general population and are most prevalent among men with higher body weights (Hudson et al.; Kinzl et al.), however, BN appears to be the most commonly treated disorder within inpatient settings (Carlat et al., 1997).

Men with clinical eating disorders consistently score higher on behavioral (e.g., drive for thinness, bulimia) and psychological (e.g., ineffectiveness, maturity fears, satisfaction with different areas of life) measures associated with disordered eating (Mangweth, Pope, Hudson, Olivardia, Kinzl, & Biebl, 1997; Olivardia, Pope, Mangweth, & Hudson, 1995; Woodside et al., 2001), and have higher rates of lifetime psychiatric disturbances, such as major depression, anxiety disorders, and alcohol dependence than men without eating disorders (Gadalla & Piran, 2007; Woodside et al., 2001). For example, Carlat et al. (1997) reported that men with BN were more likely to be homosexual, be premorbidly obese, have a parent who was overweight, and have abused alcohol than those men who had AN or EDNOS. Not only do men with eating disorders experience social, psychological, physical, and behavioral problems relative to men without that are significantly higher, their absolute level of disturbance is severe, negatively affecting the quality of their lives.

This severe level of disturbance across the social, psychological, physical and behavioral domains has been confirmed by research that has compared men and women with clinical eating disorders and found them to be more similar than different (Braun, Sunday, Huang, & Halmi, 1999; Carlat et al., 1997; Fernández-Aranda et al., 2004; Hay et al., 2005; Schneider & Agras, 1987; Woodside et al., 2001; 2004). Specifically, men and women with clinical eating disorders are similar and equally diagnosed with anxiety disorders, psychological correlates (e.g., interpersonal distrust, maturity fears, assertiveness), overall level of psychopathology, presence of phobias, reported quality of life (e.g., satisfaction with friends, family, life), level of perfectionism (e.g., personal standards, parental expectations/criticism), presence of obsessive/compulsive disorders, and responses to treatment. These studies also have shown men with eating disorders to have lower levels of lifetime major depression, less use of vomiting/laxatives, fewer concerns with and preoccupations about weight, less body dissatisfaction, lower drive for thinness, less harm avoidance, fewer concerns about mistakes (perfectionism), and lower frequency of seeking treatment for their disorder, and to have higher levels of lifetime alcohol dependence, be more likely to be homosexual, be older at time of onset for their eating disorder (approximately 19 years old), and be most likely

to play sports, particularly those focused on weight and body, than women with eating disorders. As we discuss later in this chapter, many of these differences can be explained by society's current construction of masculinity and the messages boys receive about what it means to be a man in contemporary society and how those messages are translated into behaviors, attitudes, and, for some boys and young men, psychopathology. Understanding the similarities and differences between men and women and among men with different types of clinical eating disorders can assist clinicians in identifying those who are at-risk for body image and eating disturbances and in developing more effective treatments.

Subclinical Eating Disorders

Men do exhibit behaviors that fall short of clinical diagnostic levels (Hay et al., 2005; Hudson et al., 2007; Kinzl et al., 1999; Kjelsås et al., 2004; McNulty, 1997; O'Dea & Abraham, 2002). For example, Kinzl et al. found that 4.2% of their randomly selected, community-based sample of men (aged 18-88 years), had partial BED syndrome, whereas Hudson et al. reported lifetime prevalence rates of 1.9% for subthreshold BED in a nationally representative sample of U.S. men. O'Dea and Abraham found that 9% of college men had suffered from disordered eating at some point in their lives. In samples of adolescents and adult men, the prevalence of binge eating (not full or partial BED) has ranged from 5.5% to 22% (Kjelsås et al., 2004; McNulty, 1997; O'Dea & Abraham, 2002); reported triggers include a craving for sweets, boredom/loneliness, and stress (Kinzl et al., 1999). To control their weight, men diet (prevalence rates range from 5.8% to 14.7%), but they predominately engage in excessive exercising. Men have reported that their primary motivations for exercising are to be more attractive and tone their bodies (Hay et al., 2005; Kjelsås et al.; O'Dea & Abraham), which is consistent with a pursuit of the muscular body-ideal. Less than 4% use other forms of purging, including vomiting, laxatives, and diuretics (Kjelsås et al.; McNulty). Perceived pressure from the one's environment can influence men's tendency to engage in pathogenic weight control behaviors. For example, McNulty found that two to five times more active duty navy personnel used vomiting, laxatives, diuretics, fasting, and diet pills during the period immediately prior to their annual fitness/weight evaluations than they did at other times during the year. Although clinical disorders occur relatively infrequently among men, larger numbers have subclinical problems and engage in pathogenic weight control behaviors that ultimately may lead to the development of more severe eating pathology (Leon, Fulkerson, Perry, & Early-Zald, 1995; O'Connor, Simmons, & Cooper, 2003).

Body Image Concerns

Body image is a multidimensional construct that is defined by affective (e.g., satisfaction), perceptual (e.g., body distortion), cognitive (e.g., beliefs about self) and

behavioral (e.g., use of excessive exercise) disturbances (McCabe & Ricciardelli, 2004). Although men consistently rate themselves more positively on measures of body satisfaction than women (e.g., Spillane, Boerner, Anderson & Smith, 2004), body concerns still exist for them. For example, O'Dea and Abraham (2002) found that male undergraduates worried a great deal about their shape and weight (25%), that their self-esteem was influenced a lot by their shape (16%), and that they felt fat (12%) or were unhappy about their shape (10%). Further, in a larger scale study of men, 43% reported being dissatisfied with their appearance, 52% with their weight, 45% with their muscle tone, and 63% with the shape of their abdomen (Garner, 1997). Body image concerns, in particular body dissatisfaction, are related to psychological distress (e.g., depression, low self-esteem) and are a central etiological factor in the development of eating disorders and other negative health risk behaviors, such as steroid use, use of ephedrine, and extreme dieting (Cafri, Thompson, Ricciardelli, McCabe, Smolak, & Yesalis, 2005; Olivardia et al., 2004; Ricciardelli & McCabe, 2004).

Men establish their body image through physical activity and use such activity to achieve desired levels of leanness and muscularity with a strong emphasis on one's upper body (e.g., chest, biceps, etc.) (Ridgeway & Tylka, 2005). Men, particularly college-aged, view their bodies as being smaller and less muscular than their ideal and believe women find this hypermuscular body type to be most attractive (Grieve, Newton, Kelley, Miller & Kerr, 2005; Lynch & Zellner, 1999; Olivardia et al., 2004). These findings suggest that men feel strong social pressures to change their bodies and, although one might expect only a desire to be bigger (e.g., Abell & Richards, 1996), these findings are equivocal, with one early study concluding that men are divided relatively equally between wanting to lose weight and wanting to gain weight (e.g., Drewnowski & Yee, 1987). Men report wanting to change their body shape (whether losing weight and becoming leaner, or gaining weight and becoming more muscular) primarily to be seen as more attractive to others, and using exercise, particularly weight lifting, aerobic activities and sports, as the primary mechanisms to achieve their weight and appearance goals (Ridgeway & Tylka, 2005). Although being muscular and lean generally are important to men of all ages, the extent to which boys and men focus on them appears to change as they age. McCabe and Ricciardelli (2004) have suggested that adolescent boys are more focused on increasing muscle size, whereas men pay more attention to leanness and improving muscle tone. Even so, more empirical research is needed to better understand how men's body image changes over the lifespan and what variables are most important in predicting dissatisfaction depending on age and developmental period. In addition, when assessing body image concerns in men, it is essential to focus on issues of body leanness and muscularity, in particular for areas above the waist (e.g., chest, arms), and to inquire about activity levels and the reasons why they are exercising because these are strongly linked to the way men modify their size and shape.

Muscle Dysmorphia

Although body image concerns are a central feature, muscle dysmorphia (MD) is more than just an extreme form of body dissatisfaction. MD is a type of body dysmorphic disorder (BDD) where individuals are preoccupied with their appearance and view their bodies as being insufficiently muscular. Pope, Gruber, Choi, Olivardia, and Phillips (1997) initially coined the term and proposed three essential diagnostic features: (1) a preoccupation with the idea that one's body is too small, specifically not lean and muscular enough, despite objective evidence that the body might be large and strong; (2) the preoccupation causes personal, social, and occupational distress and impairment (e.g., changing or giving up life responsibilities to be able to pursue needed/essential workouts and to follow a strict dietary regimen; avoiding public situations in which the body may be viewed or wearing clothing that hides the perceived deficits in muscularity); (3) the preoccupation is focused on being too small and not muscular enough, not on some other aspect of appearance (e.g., being too fat) or on a specific part of one's body such as is seen in BDD. Although there are no population-based studies prevalence studies on MD, researchers have indicated that prevalence is highest among men, anabolic steroid users, and body builders (e.g., Pope et al., 1997).

Research has supported the diagnostic and associated features of MD. For example, Kanayama, Barry, Hudson and Pope (2006) compared steroid users to nonusers and found that those who had used, particularly heavily, thought they were smaller and not muscular enough and were more likely to cover themselves up in public, two key features of MD. Oliosi, Grave, and Burlini (1999) reported that noncompetitive body builders, in comparison to controls, were more likely to diet, want to gain/lose weight, use anabolic steroids, and have a higher drive for thinness and overall psychopathology. In a more direct test of MD, Olivardia, Pope, and Hudson (2000) solicited the participation of body builders and then categorized them as either having or not having MD. In comparison to the control group, men with MD were more muscular, weighed themselves and checked their appearance in mirrors more often, thought more about their bodies more, were more likely to avoid showing their bodies or give up enjoyable activities, experienced more psychopathology (e.g., depression, anxiety), had higher scores on a measure of psychological and behavioral indices of disordered eating, and were more likely to use anabolic steroids. Further, Olivardia et al. (2000) reported that the mean age of onset for MD was 19.4 years, which is similar to that found for men with clinical eating disorders. In conclusion, they suggested that MD may be part of a broader class of obsessive-compulsive spectrum disorders or affective spectrum disorders that likely arise from common underlying environmental or genetic factors. They also acknowledged that MD likely is influenced by sociocultural pressures that are evident in the changing display of the male body ideal.

Central to MD is an individual's pursuit of muscularity, which may be viewed as the male version of drive for thinness. By developing the construct drive for muscu-

larity (DM; defined as the pursuit of the culturally sanctioned, hypermuscular ideal), researchers have been able to examine subclinical levels of MD, which is important because, like clinical eating disorders, so few men actually experience the full-blown disorder (Pope, Phillips, & Olivardia, 2000). In developing their scale, McCreary and Sasse (2000) posited that although both boys and girls internalize society's muscular ideal, boys would place greater importance on it, integrate it more completely into their self-conception (i.e., as what it means to be masculine), and be at greater risk for negative psychological outcomes (e.g., depression, poor self-esteem) as a result. In support of their hypotheses, McCreary and Sasse found that boys had higher DM scores than girls, and that higher scores were related to more involvement in weight training and dieting to gain muscle mass, higher levels of depression, and lower levels of self-esteem, and unrelated to the desire to lose weight. Further, men with higher DM scores are emotionally reactive, perfectionistic, and focused on their appearance and how fit their bodies are (Davis, Karvinen, & McCreary, 2005). DM also has been associated with different aspects of masculinity (e.g., characteristics, attitudes), but unrelated to femininity (McCreary, Saucier, & Courtenay, 2005), suggesting that the pursuit of the muscular ideal is a central characteristic in the masculine identity. Given the centrality of MD and DM in body image and eating disturbances and the lack of current studies in the area, these concepts represent important directions for future research. In addition, clinicians will need to pay attention not only to traditional features of eating disorders when evaluating male clients' functioning, but also those associated with MD and DM.

Risk Factors and the Development of Body Image and Eating Disturbances in Males

Body image and eating disturbances are influenced by psychological, sociocultural, physical, physiological, genetic, and familial factors. The messages, expectations and values that are communicated about how men and women should look, how they should feel about and behave towards food, and the characteristics, attitudes, behaviors and roles that they should adopt during their development are central to understanding the etiology of body image and eating disturbances in men. The psychosocial factors that are salient for men include: (a) changes in the media's portrayal of men and in the ideal male body; (b) contemporary views of masculinity; and (c) sexual orientation. In addressing these topics, we acknowledge that there are other important risk factors, such as body dissatisfaction and body size, which contribute to the development of body image and eating disturbances in men (see Cafri et al., 2005; Ricciardelli & McCabe, 2004 for more information).

Society's Portrayal of the Ideal Male Body

Historically, society has portrayed and judged men for intellect (e.g., being logical, rational) and personal accomplishments (e.g., what they could do) rather than

appearance qualities (Soban, 2006). Valued on multiple levels, none of which was associated directly with body size and shape, men generally developed a self-concept that was multi-dimensional and thus allowed for stability and health across most situations. In the last two to three decades, however, society's portrayal of men has shifted and become more similar to the depiction of women. As presented in the media (e.g., magazines, TV, movies), men now are valued primarily for how they look; it is the aesthetics of their bodies, not its functionality, that society deems important (Soban, 2006). Like women, men have become objects of beauty that are used to sell and market. And the male beauty ideal is ubiquitous and clearly defined in our society – leanness and muscularity. Soban has argued that this societal shift in the male body ideal has contributed significantly to the body image and eating disturbances that are present in increasing numbers among boys and men. Because men now are more singly defined in terms of their value, place, and role in society and are experiencing pressure from women as well as other men to achieve a body shape that is unrealistic for most (Lynch & Zellner, 1999), their risk for psychopathology, in particular body image and eating disturbances, has increased.

Research has documented the presence of the lean and muscular body ideal across many different media outlets over time (e.g., Baghurst, Hollander, Nardella, & Haff, 2006; Botta, 2003; Brownell & Napolitano, 1995; Labre, 2000; Law & Labre, 2002; Leit, Gray, & Pope, 2002; Petrie et al., 1996; Pope, Olivardia, Borowiecki, & Cohane, 2001; Pope, Olivardia, Gruber, & Borowiecki, 1999; Spitzer, Henderson, & Zivian, 1999). For example, over a period of 40 years, the size and musculature of Playgirl centerfold models increased (Leit et al., 2002; Spitzer et al., 1999), whereas the body size of men in general increased only slightly, creating a larger discrepancy between the size and shape of actual men and these cultural icons. This shift to a more muscular physique also has been documented in action figure toys. Examining changes in the figures' bodies from the early 1970s through the late 1990s, Pope et al. (1999) reported that the G.I. Joe introduced in the mid-1990s would have a 55-inch chest and 27-inch biceps if it were life-sized, a physique that even advanced body builders would have difficulty obtaining. Similarly, Baghurst et al. (2006) found that the body parts (e.g., chest, arms, thighs) of current action figures were 22% to 71% bigger than those on the original version of the same toys. Although Playgirl centerfolds may simply represent the shift in the male body ideal, the extreme body size and musculature observed in action figures is more troubling. From a very early age, boys are exposed to an unrealistic cultural body ideal.

Labre examined two popular men's magazines and found that over 95% of the pictures represented men who had low levels of body fat, whereas 82% of the pictures were of men who were rated as very muscular. In a study of two popular women's magazines, although the year of publication was unrelated to the total number of male images represented in advertisements, there was a significant increase over time in the

number of undressed male images portrayed (Pope et al., 2001). These findings suggest that the value of the male body as a commodity or an object that can be used to sell and market products has increased in value over the last few decades. Regarding article content, Labre reported that leanness/muscularity and health were the top two areas of focus in the magazines she reviewed. Similarly, Petrie et al. (1996) found that over a 30 year period there was a significant increase in the number of magazine articles and advertisements whose content focus was either health or fitness. Botta (2003) found that reading health/fitness, but not fashion or sport, magazines was related to increased concern with muscularity (e.g., taking supplements to increase muscle mass), and that adolescent boys who tended to compare their bodies with the media images also reported increased drive for thinness, and more bulimic and anorexic behaviors. In a direct test of the effects of media exposure, Leit et al., (2002) found that male undergraduates who were shown advertisements that contained the male body ideal reported a greater discrepancy between their current and ideal body shape than a control group.

Although all men are at-risk for body image and eating disturbances due to the presence of these sociocultural pressures, specific subgroups of men – body builders and athletes – may be even more vulnerable to body dissatisfaction, psychological disturbances, eating disorders, and risky weight loss and/or weight gain practices due to pressures unique to their social environments. For example, the primary athletic goal of body builders is the pursuit of an unrealistic, hypermuscular body ideal. They are judged and rewarded for being bigger, stronger and leaner than their competition. Competitive losses represent direct feedback that the body builder has not achieved the ideal physique, which may only increase the pressure he experiences to take extreme actions to change his body. In sports, some athletes (e.g., wrestling) must make specific weight limits or they cannot compete, whereas for other athletes (e.g., gymnastics) the aesthetics of the athlete's body can strongly influence the outcome of his performance. Still, in other sports (e.g., cross country), a low body weight is thought to offer a performance advantage. Thus, athletes may experience direct and indirect pressures from coaches, teammates, and judges to alter their weight, strength, body size, and/or appearance in hopes of improving their performances.

In fact, body builders do report greater levels of body dissatisfaction, ineffectiveness and perfectionism, and lower self-esteem, with increased use of anabolic steroids and high drives for muscle bulk and thinness as compared to other athletic groups (Blouin & Goldfield, 1995). In a related study, Goldfield, Blouin, and Woodside (2006) found that body builders reported high levels of preoccupation with weight and musculature, decreased body satisfaction, and eating behaviors similar to men with bulimia nervosa. Furthermore, competitive bodybuilders had higher lifetime rates of binge eating disorder than recreational bodybuilders, and were more likely to use anabolic steroids. For male athletes, regardless of sport type, they report more bulimic and

anorexic symptomatology, and have a stronger drive for thinness than nonathlete comparison groups (Hausenblas & Carron, 1999). In terms of prevalence, male collegiate athletes have rates that range from 0% to 1.8% for clinical disorders and 16.6% to 21.2% for subclinical concerns (Carter & Rudd, 2005; Petrie, Greenleaf, Carter & Reel, 2007; Sanford-Martens et al., 2005). Sundgot-Borgen and Torstveit (2004) reported prevalence rates of 0% (AN), 3% (BN), and 5% (EDNOS) for elite-level male athletes. Male collegiate athletes also engage in a variety of pathogenic eating and weight control behaviors, with lifetime prevalences of 26.6% (binge eating), 5.9% (vomiting), 5.1% (laxatives), 3.7% (diuretics), 2.2% (diet pills), and 2.0% (anabolic steroids) (Johnson, Powers, & Dick, 1999).

The studies reviewed in this section demonstrate that (a) there has been a general sociocultural shift toward a greater focus on issues of men's health and fitness and subsequently on the male physique, (b) current media images of male models have become increasingly lean, muscular and unrealistic, (c) exposure to, and in particular comparing oneself with, media images of the male body ideal can increase men's risk of body image and eating disturbances, and (d) specific subgroups of men may be at increased risk because of the additive effect of the pressures unique to their environments. These studies also show that, although men are immersed in a sociocultural environment that presents an unrealistic hypermuscular and lean body-ideal and are experiencing increasing pressure to conform to these body images, exposure is not sufficient to cause the development of body image and eating disturbances. As proposed in etiological models (e.g., Cafri et al., 2005), men must internalize these images, actively and directly compare themselves to the images, and then evaluate themselves as falling short, which is likely given that the ideal is so extremely different from that of the average male body (Spitzer et al., 1999). In such instances, men are likely to experience body image concerns and have an increased chance of developing disordered eating attitudes and behaviors.

Contemporary Views of Masculinity

The idea that masculinity is socially constructed, that is, defined by society and communicated through the socialization process that unfolds as boys develop through adolescence and into adulthood, is not new. In fact, it is through this socialization process that boys learn what it means to be masculine and a man in today's society (Soban, 2006). Because masculinity is socially constructed, the definition of what it means to be a man has changed over time. Drummond (2002) has suggested that current conceptions of masculinity include the following characteristics/values/beliefs and that these are communicated to boys by families, friends, teachers, coaches, and the media: (a) do not admit being weak or ill, particularly concerning psychological issues; (b) do not ask for or seek help from others (be independent); (c) endure pain and do not complain; (d) your appearance and body are central to your worth as a per-

son and its value is determined by how lean and muscular it is; (e) pursue weight loss through exercise and activity, not diet; (f) participate and achieve success in sports; and (g) be competitive, but mostly be successful, in career and life. Similarly, Soban (2006) has argued that men's value has shifted from what they know and what they can do, to how they look.

Given that contemporary men are increasingly being valued and defined by their bodies (with a specific ideal that is expected of them), and that many of these characteristics of masculinity (e.g., endure pain, do not admit being weak, exercise for weight loss) are similar to the traits found in women with AN (Thompson & Sherman, 1999), it is not surprising that men are at-risk for the development of body image and eating disturbances. Initial research appears to support this contention, with male-typed characteristics, beliefs, and behaviors being associated positively with the drive to pursue a more muscular physique (McCreary et al., 2005). Although the idea that contemporary views of masculinity may underlie or increase risk for body image and eating disturbances is important, more research is needed before this relationship can be firmly established. In addition to examining directly the relationship of masculinity, as defined through characteristics, attitudes and behaviors, to different aspects of body image and eating disturbances, researchers may want to study the discrepancies between men's perceptions of how they actually are in terms of their masculinity and how they ideally would like to be. Men who are content with their masculinity (and thus are not striving to be "more masculine") may be at lower risk for body image and eating disturbances than men who view themselves as lacking in some way in terms of what it means to be a masculine in today's society.

Sexual Orientation

It is not homosexuality per se that likely increases the risk of body image and disordered eating among men, but psychological and social factors that are present among gay men and within the gay culture. From a sociocultural perspective, the gay culture strongly emphasizes body and appearance (Soban, 2006). As Harvey and Robinson (2003) noted, looking fit (i.e., lean and muscular) and being attractive are very important for obtaining relationships among gay men. In response, gay men may become overly focused on their body size, shape, and appearance and then engage in extreme behaviors in attempts to achieve the more desired look. From a psychological perspective, gay men often experience high levels of depression and low self-esteem (Harvey & Robinson, 2003), which are known risk factors for body image and eating disturbances. When combined with discomfort gay men might have about their sexual orientation, particularly early in their coming out process, these psychological factors may interact to lead them to being dissatisfied with their bodies and potentially developing disordered eating attitudes and behaviors. Finally, from a gender role perspective, femininity has been associated with higher levels, and masculinity with lower

levels of body image and eating disturbance (Murnen & Smolak, 1997), and gay men tend to score higher on measures of femininity and lower on those associated with masculinity (e.g., Meyer, Blissett, & Oldfield, 2001). Independently or in combination, these three factors may work to increase gay men's risk of developing body image and eating disturbances.

Research does suggest that gay men do experience higher levels of BN than found in heterosexual men and would be expected given gay men's prevalence in society (Carlat & Camargo, 1991). For example, Carlat et al., (1997) found that, over a 15 year period, 42% of the male patients treated for BN were either gay or bisexual. Further, among male university students, 2% of gay men could be diagnosed with a past eating disorder, whereas the lifetime prevalence for heterosexual men was only .33% (Yager, Kurtzman, Landsverk, & Wiesmeier, 1988). In a study examining risk factors associated with body image and eating disturbances in gay men, Hospers and Jansen (2005) found that masculinity, but not femininity, was related to body dissatisfaction. Gay men who reported strongly identifying with traditional masculine characteristics had the lowest levels of body dissatisfaction. For eating disorder symptoms, however, both masculinity and femininity were unrelated. These findings suggest that gender role's effects on disordered eating may be indirect and mediated through body satisfaction. More research is needed, though, to explore these potential effects.

Researchers also have compared gay men directly to heterosexual men and women on a wide range of psychological and behavioral correlates of eating disorders (e.g., Brand, Rothblum, & Solomon, 1992; Kaminski, Chapman, Haynes, & Own, 2005; Williamson & Hartley, 1998; Yager et al., 1988; Yelland & Tiggemann, 2003). Based on their findings, gay men have been shown to be more preoccupied with their weight and to report higher levels of body dissatisfaction than heterosexual men. Further, gay men have a greater fear of becoming fat and drive for muscularity than non-gay men and a drive for thinness that is equivalent to the very high levels found among heterosexual women; this finding supports the notion that the gay male ideal is defined by both thinness and muscularity. Regarding psychological variables, gay men, compared to heterosexual men, have more maturity fears, feel less effective, and hold more irrational beliefs about their bodies. Finally, on behavioral indices, gay men report more disturbances on measures of bulimic symptoms, dieting, and oral control. Although these studies suggest that gay men, for the reasons stated earlier, are at increased risk for body image and eating disturbances, the reality is that the findings are based on cross-sectional data, so no firm conclusions about risk can be made. Researchers will need to conduct longitudinal studies to determine the extent to which the gay body culture, masculinity/femininity, or depression, self-esteem, and discomfort with sexual orientation truly predict the development of body image and eating disturbances.

Clinical Implications

Men do suffer from clinical and subclinical levels of body image and eating disturbances and experience a wide range of psychological, social, physical and behavioral disturbances associated with these disturbances. Despite this fact, and that over the last two decades men's pursuit of eating disorder treatment has increased (Braun et al., 1999), most men do not seek treatment assistance because of a variety of real and perceived barriers. These barriers may include: masculine gender roles, the stigma of having a "woman's illness," and physicians, psychiatrists and psychologists who under-diagnose or do not recognize the disorder among men. To prevent these problems from continuing and assist men in receiving the help they may need, clinicians should recognize and address the following issues:

1. Because of the stigma associated with the label of a "woman's disorder," men may not seek treatment directly for body image and/or disordered eating issues. Rather they are likely to present with other problems that they consider more "acceptable," such as, depression, anxiety, low self-esteem, perfectionism, gender identity, alcohol abuse, or weight management. Thus, clinicians should be willing to explore the possibility that these men also have concerns about their body image and perhaps may be experiencing clinical or subclinical eating disorders.

2. There are specific subgroups of men (e.g., body builders, athletes and gay men) who may be more at-risk for developing body image and eating disturbances. Thus, clinicians should be willing to inquire about issues of body image concerns, use of dietary supplements (e.g., creatine, anabolic steroids), excessive exercising, and other pathogenic eating and weight control behaviors when working with men from these subgroups.

3. Because men and women with AN and BN share many of the same psychological and behavioral disturbances associated with the disorders, standard multidisciplinary forms of treatment that include medical, psychological/psychiatric and nutritional interventions are recommended (Andersen & Holman, 1997; Weltzin, Weisensel, Franczyk, Burnett, Klitz, & Bean, 2005). However, when working with men, clinicians also should pay attention to and, when necessary, address the following issues:

    a. Eating disorders are not "women's disorders" and there is no stigma associated with seeking treatment for having one.

    b. It is beneficial for men to ask for help and support; it is not a sign of weakness and thus men should be reinforced and supported for engaging in such behavior.

    c. Expressing emotions, particularly about self, body, and relationships is essential for recovery.

   d. Contemporary views of masculinity may be contributing to men's problems with body image and eating disturbances; thus, the patient's view of what it means to be a man can be challenged and broadened.

4. Men's conception of the body ideal is very different than women's – being defined by leanness and muscularity as opposed to thinness (Ridgeway & Tylka, 2005). Thus, clinicians need to look for behaviors associated with the pursuit of muscularity (e.g., weight lifting, anabolic steroid use, excessive exercising) and not the pursuit of thinness (e.g., dieting).

5. Because sociocultural pressures now are pervasive for men, during treatment clinicians should confront the unrealistic nature of the contemporary body ideal and give men the opportunity to move beyond it ("I am valued solely for my body and how I look") to reclaim a broader, multiply-defined self-concept.

6. Because the age of onset for clinical eating disorders is older for men than women, clinicians may want to target prevention programs for the beginning of high school when boys still are developing physically and defining their identities. Programming that addresses sociocultural pressures, masculinity in today's society, and developing and maintaining self-esteem may be useful (Soban, 2006).

7. Physicians, psychiatrists, psychologists, and counselors who work with men need to remove their blinders and recognize that men do experience clinical and subclinical levels of body image and eating disturbances, though they may not present symptoms that are traditional indicators of disordered eating.

Research Implications

Research on men with body image and eating disturbances is in its infancy, particularly in comparison to that which has been conducted in women. Thus, before firm conclusions can be drawn concerning the etiology, prognosis and treatment of body image and disordered eating among males, additional research must be conducted. Researchers may want to consider the following avenues when designing future studies on men with body image and eating disturbances:

1. Use within subject designs to examine the extent to which psychological, social, and behavioral variables "predict" different outcomes, such as body dissatisfaction, drive for muscularity, or bulimic symptoms.

2. Examine multi-factorial models of body image and eating disturbances, such as those proposed by Cafri et al. (2005) and Ricciardelli and McCabe (2004), to determine the extent to which variables singly or in combina-

tion explain the development of body image and eating disturbances. The use of structural equation modeling would be appropriate to test the relationships proposed in such models and to examine the mediators of the relationships.

3. Begin with cross-sectional methodologies to test multi-factorial models and to examine relationships among variables that have not been fully tested (e.g., gender discrepancy and drive for muscularity) (Stice, 2002), but once relationships among variables have been established then move to longitudinal and experimental designs, which are the only ways to determine whether a variable is an actual risk factor in the development of body image and eating disturbances. In particular, longitudinal studies should track individuals over multiple years, such as from the beginning of middle school through high school.

4. Examine potential moderators of the relationships between sociocultural pressures and body dissatisfaction or between body dissatisfaction and the development of either BN or DM. Variables such as body mass, perfectionism, body surveillance, neuroticism, achievement motivation, modeled behaviors of family/friends, to name just a few, that have been studied with women (Brannan & Petrie, 2008; Tylka, 2004) would be a logical place to start. In addition, when studying men, researchers may want to consider other variables, such as comfort with sexuality, alcohol use, and involvement in sports, which may increase risk, as well as those, such as social support, masculinity, self-esteem, and optimism, which may offer protection from the otherwise deleterious effects of the sociocultural environment.

5. Although there have been improvements in measurement, more research is needed in the assessment of key concepts, such as body image concerns and the pursuit of muscularity. Research is needed to further test existing measures as well as develop new ones that are psychometrically valid and reliable and practical to use with males in a clinical context.

6. Although some researchers (e.g., Ricciardelli & McCabe, 2004) have focused extensively on the development of body image and eating disturbances among boys and adolescents, more research is needed within these age groups. In particular, researchers should focus on the middle school and early high school years when boys are experiencing the physical and psychological changes associated with puberty, are defining their identities separate from their parents, and are coping with the pressures (e.g., dating, academics, teasing) of adolescence. In such studies, researchers should not only examine traditional outcomes, such as body dissatisfaction or disordered eating symptoms, but also drive for muscularity, which may be a more prevalent problem for boys and men.

Summary and Conclusion

In the past two decades the sociocultural environment for men has changed, and not to their advantage. Like women, the importance of how men look has increased and become idealized, though this body ideal is defined by leanness and muscularity as opposed to thinness. As a result, men now experience more clinical and subclinical body image and eating disturbances and comorbid psychological disturbances than in the past. In addition, contemporary masculinity represents a risk factor for men as well as a potential obstacle to seeking treatment. As a result, men may be less willing to seek treatment for body image and eating disturbances, which leaves them isolated and at-risk for other psychological problems.

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