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Gender Differences in Treating Adolescents with Eating Disorders

By

Cameron Green, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of

Master of Social Work

Committee Members
Valandra, MBA, MSW, PhD, LISW (Chair)
Rebecca Sorenson, LICSW
Katie Murray, PsyD, LP

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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Abstract

Previous research indicates that female and male adolescents have many differences and similarities in contributing factors to and treatment of eating disorders. The goal of this study was to further explore treatment differences between male and female adolescents with eating disorders. Other objectives in this study explored the contributing factors to eating disorders, treatment success rates among respondents, and treatment modalities used by respondents. The present study explored the following research question: What are the similarities and differences between genders in treating adolescents with eating disorders? This is an exploratory design with a quantitative research design. The findings of this study appear to be consistent with past literature. A combination of factors was listed as contributing the most to eating disorders in adolescents. Respondents indicated that treatment modalities for both genders are very similar as well as contributing factors to eating disorders. The treatment modalities indicated as most successful with adolescents with eating disorders were cognitive behavioral therapy and a multidisciplinary approach. Treatment approaches used by respondents were indicated as very successful with both male and female adolescents. Further research is needed to explore the racial differences within eating disorders as well as more research on males with eating disorders.

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One of the most heartbreaking things is watching a young person struggle with an eating disorder. An eating disorder is defined as, “unhealthy relationship with food and weight that interferes with many areas of a person’s life” (National Association of Anorexia Nervosa and Associated Disorders (ANAD), 2012). Having an eating disorder is more common than most people realize, with up to 24 million people suffering from an eating disorder in the U.S. (Renfrew Center Foundation for Eating Disorders, 2003). Over time eating disorders can have many negative effects on the human body, including problems with the heart, stomach, intestines, and esophagus. In addition, eating disorders have the highest mortality rate of any mental illness (Crow, Peterson, Swanson, Raymond, Specker, Eckert, & Mitchell, 2009). This disease can cause multiple problems physically in the people who suffer, with the impact being greater on children and adolescents developing bodies.

The ANAD reports that over one-half of teenage girls and nearly one-third of teenage boys use unhealthy weight control behaviors (Neumark-Sztainer, 2005). Some habits include skipping meals, fasting, smoking cigarettes, vomiting, and taking laxatives (Neumark-Sztainer, 2005). Teenage girls with eating disorders have been studied extensively, and only recently have studies covered males. The American Journal of Psychiatry reported that an estimated 10-15% of people with anorexia or bulimia are male (Carlat & Camargo, 1997). Even though this is a much smaller percentage of the U.S. population, it is important to provide treatment for teenage males with an eating disorder.

Treatment is also hard to provide for this population because of the perception of having an eating disorder. Men are less likely to seek treatment for eating disorders

because of the perception that they are diseases for women (Carlat & Camargo. 1997). In addition, only 35% of people that receive treatment for eating disorders get treatment at a specialized facility for eating disorders (Noordenbox, 2002). It is tough to recover from this illness if the appropriate help needed from a specialized treatment center is not being received. Men have more trouble recovering from an eating disorder because they are less likely to seek treatment.

Literature Review

Before diving into the literature on eating disorders it is necessary to define the main terms that are discussed in the remainder of this project. This will cover defining anorexia nervosa (AN), bulimia nervosa (BN), and other important terms.

The Diagnostic and Statistical Manual of Mental Disorders fourth edition text revision (DSM-IV-TR) (2000) defines AN as a refusal to maintain body weight greater than the minimally normal weight for age and height, which is listed at less than 85%. An individual with AN also needs to have an intense fear of weight gain even though underweight, and a disturbance in the way one's body weight, size, or shape is experienced (DSM-IV-TR, 2000). Within the AN diagnosis there are two types: restricting and binge eating/purging. The restricting type does not regularly engage in binge eating or purging behavior (DSM-IV-TR, 2000). The binge eating/purging type does regularly engage in binge eating or purging behavior (DSM-IV-TR, 2000).

The DSM-IV-TR (2000) defines BN for both males and females as recurrent episodes of binge eating followed by recurrent inappropriate compensatory behaviors to prevent weight gain. Binge eating can be characterized by both eating, within a discrete period of time, an amount of food that is definitely larger than most people would eat in a similar period of time, and a sense of lack of control over eating during the episode (DSM-IV-TR, 2000). The behaviors to prevent weight gain include: self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting, or excessive exercise (DSM-IV-TR, 2000). In addition, to be diagnosed with BN a person needs to both binge eat and prevent weight gain at least twice a week for 3 months (DSM-IV-TR, 2000). The two types of BN are purging and non-purging. The purging

type regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, or enemas while the non-purging type uses other inappropriate compensatory behaviors (DSM-IV-TR, 2000). After defining how both AN and BN are diagnosed, it is now time to look at past research on the topic.

When it comes to the literature surrounding eating disorders, the scale leans heavily to research regarding females. As this literature review will show, there are more studies investigating the factors that lead to an eating disorder, the characteristics of someone with an eating disorder, and the effective treatments for these individuals. This literature review will look at the risk factors that lead to eating disorders in women and female adolescents, some important characteristics that come with eating disorders, and treatment approaches for women and female adolescents. Then this researcher will look at the literature on male adolescents and compare findings to that of female adolescents for risk factors, characteristics that come with an eating disorder, and treatment approaches. This is all done to determine a way to answer the research question of: What are the similarities and differences between genders in treating adolescents with eating disorders?

Factors that Can Lead to Eating Disorders in Females

After reading many articles and studies about eating disorders, it can be said that there are many factors that can lead to this disease. There are family influences on an individual from marital conflict to negative relationships with the parents. Many social factors are becoming increasingly prevalent in this country, and are influential on the thinking of young females and males. This can include advertisements, magazine articles, television programs, and the Internet. Lastly there are risks when an individual reaches

puberty and becomes increasingly aware of his or her body image. There is not one definite factor that causes an eating disorder, but there are many factors in the process.

Family Influences

Many researchers have completed studies looking into the different factors that can contribute to an adolescent developing anorexia nervosa. Several researchers have determined the influence of family factors on developing this disease. Latzer, Lavee, and Gal (2009) collected data from 30 adolescent females with an eating disorder and both biological parents to determine what, if any, influence family has on the etiology of eating. Latzer, et. al (2009) concluded that marital quality and the “severity of eating-related psychopathology” have a negative correlation, that is to say that as marriage quality decreases, the severity of eating-related psychopathology of the daughter increases. Latzer and Gaber (1998) conducted a study looking at conflict within a family with a daughter with AN compared to a control group without anyone with an eating disorder. These researchers concluded that AN families chose to talk about food during their conversations significantly more than the control families, even though this was a large point of conflict within their family (Latzer & Gaber, 1998). These researchers agreed with past studies that dysfunctional family dynamics are associated with eating disorders (Benninghoven, Schneider, Strack, Reich, & Cierpka, 2003; Wisotsky, Dancyger, Fornari, Katz, Wisotsky, & Swencionis, 2003; Latzer, et. al, 2009). The dysfunctional family dynamics may lead to many stressors in the life of an adolescent.

In addition to conflict within the family, the presence of abuse on a child can cause detrimental effects. Carter, Bewell, Blackmore, and Woodside (2005) studied the impact of childhood sexual abuse in patients suffering from AN. In this study, childhood

sexual abuse was defined as sexual abuse occurring before the age of 18. Results from this study concluded that 48.1% of the participants reported a history of childhood sexual abuse and 84% of these individuals “experienced more than one episode of sexual abuse” (Carter, et al., 2005). Results from this study agreed with past findings that sexual abuse leads to feelings of shame, guilt, and low self-esteem, which can lead to an increased risk of psychopathology for eating disorders (Steiger & Zanko, 1990; Thompson & Wonderlich, 2004; Welch & Fairburn, 1994; Wonderlich, Brewerton, Jolic, Dansky, & Abbott, 1997; Carter, et al., 2005). While dysfunctional family dynamics and sexual abuse can contribute to the psychopathology associated with eating disorders, they are not the only factors that can contribute to eating disorders. Another important factor to consider is the impact society has on an individual.

Sociocultural Influences

Even though disorganized families have been shown to influence eating disorders among adolescent females, the media plays another large role. Once young girls start watching television, reading magazines, or looking at billboards, they are bombarded with images of skinny and beautiful women. These young girls may make unconscious comparisons between their figure and the “ideal” figure shown through media outlets. Even adult women can make social comparisons that negatively affect their body image. Trottier and Herman (2007) looked at the effect of reading about thin peers on restrained and unrestrained eaters. At the end of this study, a few important conclusions were made about the effect of social comparisons on body satisfaction. After reading about their thin peers, the restrained eating group perceived themselves as “more overweight and reported more body dissatisfaction and lower appearance self-esteem” than did the restrained

eaters who read about their average weight peers (Trottier & Herman, 2007). Also, there was a large disparity of body dissatisfaction between the restrained and unrestrained eating groups after reading about their thin peers (Trottier & Herman, 2007). This study adds to past research that social comparisons of body weight among peers may contribute to the worsening of body satisfaction and self-esteem in females both young and old, and can contribute to the development of more serious eating problems (Carlson Jones, 2001; Kulik, 2002; Trottier & Herman, 2007). These social comparisons may lead adolescent or adult females to actively compare their weight to that of peers. This is influential in leading adolescent females to form either a negative or positive identity (Carlson Jones, 2001; Lin & Kulik, 2002; Trottier & Herman, 2007). In addition to social comparisons, media can influence how adolescents form their identity.

Media images can play a large part in influencing poor eating habits and body dissatisfaction among young girls and women. Dittmar, Halliwell, and Stirling (2009) realized the impact of media images and how often women internalize these expectations, and conducted a study to review how pictures of thin models impact women. During this study, many women who exhibited a thin-ideal internalization were shown pictures of thin models and then given a Weight-Related Self-Discrepancy Index. These researchers concluded that there are exposure-activated self-belief patterns and associated negative body-focused affect that are used to understand the impact of images of thin models on a woman's body image (Dittmar, et. al, 2009). This study agreed with past studies that images of thin models exposed to women can still cause acute negative exposure effects (Grogan, 2008; Levine & Harrison, 2004; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999; Dittmar, et. al, 2009). While media can lead to body dissatisfaction, the

Internet is more apt to influence adolescents in our society. The main source of information currently comes from the Internet, and is a constant source of scrutiny and pressure for adolescent females. The Internet has a lot of influence over the adolescents in this country.

The Internet provides websites that are in favor of being unhealthily skinny, called pro-anorexia (pro-ana) sites. The Internet also supplies adolescents with eating disorders the outlet to see women they idealize and are able to minimize their eating disorder symptoms. These individuals that spend copious time on the Internet generally have a negative view of their self (Curry & Ray, 2010). In addition, as Internet usage rises, so does the commitment by adolescents to deny social interaction and a greater idealization of thin celebrities (Curry & Ray, 2010). The internet can show itself to be quite dangerous for these adolescents. The Internet may indirectly influence adolescent females and provide a unique form for anorexia (Curry & Ray, 2010). These individuals that suffer from eating disorders may also find a community of support for self-destructive behaviors (Curry & Ray, 2010). There are also pro-ana support groups available on the Internet. These support groups provide adolescents with eating disorders the community to “foster proanorexia behaviors as they offer a sense of belonging in a like-minded community” (Curry & Ray, 2010). This can lead to further isolation of adolescents with eating disorders and can influence restrictive eating tendencies.

Puberty Risks

While many researchers contend that there are certain adolescents at risk for an eating disorder, some researchers think otherwise. Many researchers contend that all adolescent females have problems with dieting or restricting food at that age (Attie &

Brooks-Gunn, 1989, Levine & Smolak, 1992; Levine, Smolak, Moodey, Shuman, & Hessen, 1994; Smolak, Levine, & Striegel-Morre, 1996). They postulate that eating problems emerge in response to physical changes of the pubertal period, which can include increased desire for peer acceptance and the onset of dating for many adolescents. Attie and Brooks-Gunn (1989) added that there are also psychosocial influences on the adolescent, but it does not play a strong role in development of eating habits until mid to late adolescence. These researchers stated that the reason so many girls develop eating disorders around the same period of their life is because this is when most adolescent girls are completing puberty. At this time, girls concern themselves with body shape more and are concerned about body fat (Attie & Brooks-Gunn, 1989; Levine & Smolak, 1992; Levine, et. al, 1994; Smolak, et. al, 1996).

Characteristics of Eating Disorders in Females

When talking about eating disorders in females it is important to discuss factors contributing to its cause and the resulting characteristics that are displayed. These characteristics range from drive for perfection and thinness to cognitive distortions to extreme feelings of isolation and loneliness. All describe how females with eating disorders act or think while affected with either AN or BN.

Perfectionism and Eating Disorders

The first characteristic that is seen in females with eating disorders is the drive for perfection. Perfectionism has been linked in the past to depression, anxiety, and eating disorders (Flett & Hewitt, 2002). Bardone-Cone (2006) studied the possible relationship between perfectionism and disordered eating across multiple time points. Perfectionism in small doses is not a bad thing, but can be dangerous when this concept consumes every

part in the life of someone. Bardone-Cone (2006) measured perfectionism through the Multidimensional Perfectionism Scale, and the self-oriented perfectionism and socially prescribed perfectionism subscales. That study conducted an extensive set of scales in assessing dieting over an 11-week time span, bulimic symptoms, and negative affect in all 426 women. Bardone-Cone (2006) concluded that participants that had high bulimia scores also had significantly higher perfectionism scores on all measures, but especially high in the socially prescribed perfectionism category. In addition to those with bulimic tendencies, the women with high self-oriented perfectionism also tested at extreme levels of dieting (Bardone-Cone, 2006). These findings support previous research that females with either AN or BN have higher levels of perfectionism after several scales were administered (Enns & Cox, 2002; Cockell, Hewitt, Seal, Sherry, Goldner, Flett, 2002; Bastiani, Rao, Weltzin, and Kaye, 1995; Lilenfeld, Stein, Bulik, Strober, Plotnicov, Pollice, 2000). This perfectionism trait has been shown to come both from society and from within, and suggests that wanting to be perfect can have a damaging effect on eating habits.

Drive for Thinness

When there is an absolute concern about being perfectly thin, a person may go to all lengths to appear thin. Some ways to accomplish this is to be overly physically active and restrict your eating. Vansteelandt, Rijmen, Pieters, Probst, and Vanderlinden (2006) decided to look at the desire of eating disorder patients to be thin, how they regulated their affect, and urges to be physically active. High levels of activity become dangerous when someone who is restricting their diet or not fueling their body correctly is performing the activity. Vansteelandt, et. al (2006) gave a questionnaire to 32 female

patients with eating disorders to determine if there were any significant relationships between drive for thinness, urge to exercise, and affect regulation in these patients. Results from this study show just how important exercise can be to people with eating disorders. Vansteelandt, et. al (2006) concluded that patients with the lowest BMI display the highest levels of both urge to be physically active and physical activity. It was concluded that those who have chronically negative affect also have the strongest urge to be physically active (Vansteelandt, et. al, 2006). It is concerning to see that low levels of BMI are related to the highest drive to be physically active, but it does show the pathological thinking patterns present in the minds of these women. Drive for thinness was also strongly related with the urge to be physically active and physical activity (Vansteelandt, et. al, 2006). These patients overvalue the concept of being thin and how it relates to their inner happiness. In addition, Vansteelandt, et. al (2006) concluded that emotional states were significantly associated with physical activity within patients. These patients with eating disorders rely emotionally on exercising, and it is a crushing blow if they cannot do it. The drive to be thin, accompanied by extensive exercising, is one major factor in influencing the onset of an eating disorder. It is also one aspect of dysfunctional thinking that affects those with eating disorders (Vansteelandt, et. al, 2006).

Cognitive Distortions and Eating Disorders

As therapists look to treat eating disorders, they change lives by effectively changing incorrect thinking patterns. The concept of dysfunctional thinking is rampant within the ranks of eating disorders. Rawal, Park, and Williams (2010) conducted a lengthy study to compare rumination, experiential avoidance, and dysfunctional thinking

between inpatients with AN and university students. These researchers gave out questionnaires and conducted interviews with many university students and 15 inpatients with anorexia to determine if there was a difference in cognitive thinking between the two groups. Rawal, et. al (2010) concluded that participants with anorexia were much more likely to endorse dysfunctional thoughts about eating, weight and “shape control” contributing more likely to “cognitive, emotional, and behavioral consequences.” In agreement with these results, Connan, Dhokia, Haslam, Mordant, Morgan, Pandya, and Waller (2008) similarly concluded in their study to review cognition patterns in 100 patients with eating disorders and a personality disorder that avoidant and obsessive-compulsive personality disorder cognition were most clearly related to the eating-related cognitions. The avoidant and obsessive characteristics in people can be related to similar characteristics in people who have eating disorders. This is also another form of dysfunctional thinking that takes shape with individuals with eating disorders. Cotrufo, Gnisci, and Caputo (2005) reviewed the psychological characteristics of less severe forms of eating disorders to look into the mind of those at risk for eating disorders. These researchers surveyed over 200 females at risk for eating disorders, determined by their weight and general health (Cotrufo, et. al, 2005). Cotrufo, et. al (2005) concluded that an eating disorder generally begins with the anorexia psychopathological pattern. In addition, Cotrufo, et. al (2005) listed several thinking patterns they found to be prevalent in their at risk participants, including: low self-esteem, fear of gaining weight, drive for thinness, and body dissatisfaction. With incorrect thinking patterns, those suffering from eating disorders are going to use these thoughts to make and maintain incorrect eating habits. As stated earlier, incorrect eating habits can lead to severe health concerns. As

researchers look more at thinking patterns of women with eating disorders, they are able to determine more effective treatment patterns.

Somatoform Dissociation

Eating disorders take on many shapes and forms with symptoms in patients. One symptom of eating disorders is dissociation among those that it affects. Many people with eating disorders use dissociation to cognitively and emotionally avoid situations as they come up. Waller, Babbs, Wright, Potterton, Meyer, and Leung (2003) were concerned with the role of somatoform dissociation in eating disorders and pathological eating behavior. Waller, et. al (2003) studied the levels of dissociation, using the Dissociative Experiences Scale (DES-II) and the Somatoform Dissociation Questionnaire (SDQ-20), of 131 women who met the DSM-IV criteria for an eating disorder (Waller, et. al, 2003). Waller, et. al (2003) concluded from their results that although restrictive anorexics had normal levels of dissociation, anorexics that binged and purged had the highest levels of dissociation. Within individual compensatory behaviors for these women, there are higher levels of somatoform dissociation (Waller, et. al, 2003). Results from this study help lead to more treatments that could focus on the somatoform dissociation techniques that many binge-purge anorexics use. In addition to dissociation, many anorexics ask for help from time to time.

Isolation and Loneliness

When people suffering from eating disorders have a tough time opening up emotionally with anyone, they can become lonely and isolated. This isolation can even lead to relapse of patients during their treatment for eating disorders. Other researchers in the past have connected the impact of the feeling of isolation on women with eating

disorders, primarily linking these feelings with thoughts that nobody will understand what they are going through (Hall & Cohn, 1999; Zerbe, 1995; Zraly & Swift, 1990). Stewart (2004) reviewed the importance of isolation and loneliness for a patient who is receiving treatment for an eating disorder, and if this can lead to relapse. Stewart (2004) presented two cases from her experiences of women with eating disorders who had finished treatment for eating disorders. After these women graduated from treatment, each began to feel lonely and isolated in their endeavors. They were characterized as feeling as if they had no emotional support and needing more help (Stewart, 2004). The researcher in this study increased the amount of therapy sessions for these clients per week to combat the feelings of loneliness, and each patient began to improve and return to a healthy weight (Stewart, 2004). This study seems to point out how important a solid therapy is to a client and should encompass all the important aspects in the life of a client. While some females with eating disorders feel isolated from others in their recovery, others reach out for help through hotlines or support groups.

Asking for Help

While it is one thing to receive treatment, this process starts with the client asking for help. Many females with eating disorders do not seek help despite their need for treatment, support, and guidance (Fairburn & Wilson, 1993; Latzer & Shatz, 1999; Schoemaker, 1995). To test the effectiveness of a program to prevent and treat eating disorders, Latzer and Gilat (2005) conducted a study of hotline callers who were suffering from eating disorders. After this study was completed several important results were discovered. Not only were many of the anorexic callers not seeking treatment, they were more suicidal than callers with bulimia (Latzer & Gilat, 2005). Many of these

women with AN were feeling either shame or calling for moral support. This is consistent with past findings that hotlines are easier for women with AN to use, primarily because this makes the support anonymous and the caller can decide when to get the help she needs (Gilat, Lobel & Gil, 1998; Reese, Collie & Daniel, 2002). From this hotline survey, Latzer and Gilat (2005) discovered that more than half of the anorexic callers had “applied for professional treatment before calling the hotline,” and many had turned to the hotline after “feelings of frustration” toward their therapist (Latzer & Gilat, 2005). Although treatments for eating disorders are multi-faceted, the relationship with the therapist is crucial for success. These women were looking for the emotional support for their disease, which can be difficult to find at times.

Treatment Modalities and Females

While determining the best approach to treating eating disorders in women, many different types of treatments were used. A number of these treatments have been proven successful with eating disorders. Several of these are listed below and include the boundary-control model, cognitive behavior therapy, Maudsley therapy, and feminist therapy. Some have been tested often and been proven successful while a couple have not been studied as often but still found to be a success in treating eating disorders in women.

Boundary-Control Model

To understand both the causes and the most effective treatment for eating disorders is a tough task for any therapist. With so many treatment modalities available, picking the correct one usually depends on the individual. After extensive research on adolescent females, Blank and Latzer (2004) propose the Boundary-Control Model, which has an emphasis on boundaries and control for the individual involved. This model

states that a lack of fulfillment with the four basic needs (Belonging, Mastery, Pleasure, and Meaningfulness) can lead to increased anxiety, sense of insecurity and the inability to accept criticism (Blank & Latzer, 2004). When this happens to an adolescent, she will try to take control over some aspect of her life, which is eating behavior (Blank & Latzer, 2004). As the adolescent gets older, the feeling of control becomes powerful and necessary to function. When focusing their Boundary-Control Model for treatment on control issues with eating disorder patients, Blank and Latzer (2004) look at two processes: “provoking extreme anxiety in the patient by taking away her control” and “concurrently containing the anxiety by assuming leadership, authority, control, and extreme limit-setting by parents and other adult agents.” This approach to treating eating disorders was not tested on patients when written in 2004, but offers good insight into the psyche of adolescents with eating disorders.

Cognitive Behavioral Therapies

Cognitive behavior therapy exists to educate patients that their thoughts influence their behaviors and emotions negative or positive. With eating disorders, it is focused on changing incorrect thoughts related to weight, eating, and self-esteem. Byrne, Fursland, Allen, and Watson (2011) looked at the efficacy of an enhanced cognitive behavior therapy (CBT-E) while using an open trial at an outpatient clinic in Australia. Treatment consisted of several assessment meetings followed by 20-40 50 minute therapy sessions that aims to engage the client, then look at thinking barriers for each patient, then put an emphasis on changing incorrect thoughts, and the final stage focuses on maintenance and relapse prevention (Byrne, et. al, 2011). The patients with lower body mass index (BMI), a signal of lower weight in relation to height, received more therapy sessions than those

with a higher BMI. After 125 patients took part in therapy, many conclusions were made about the efficacy of CBT-E. Byrne, et. al (2011) concluded that CBT-E was effective in patients making significant improvements in “both eating and more general psychopathology.” In addition, two thirds of the patients who completed treatment achieved full or partial remission with 56.1% in full remission (Byrne, et. al, 2011). Although there was a dropout rate of about 50% for this trial, these results are encouraging for the efficacy for a cognitive-based therapy. Cohen, Simpson, and Bride (2004) agree that cognitive behavior therapy effective in treating eating disorders, although they contend it is more effective in treating BN than AN. These researchers add that at both 6-month and 1-year follow-ups patients tend to have more positive attitudes towards shape and weight (Cohen, et. al, 2004). It is also noted that Cohen, et. al (2004) believe that this type of treatment requires many therapy sessions, often requires hospitalization, and has a high dropout rate. In addition cognitive behavior therapy being effective in treating eating disorders, researchers have also had success using other experimental treatments.

Maudsley Therapy

One therapy that has been studied and used frequently is Maudsley therapy. This therapy focuses on family-based interventions in which parents play an active role in the recovery of their child. Bean, Louks, Kay, Cornella-Carlson, and Weltzin (2010) evaluated 16 adolescent female patients pre and post-treatment while using a Maudsley approach to therapy. To evaluate this therapy, Bean, et. al (2010) looked at many different symptoms, including: depression, anxiety, obsessive-compulsive behaviors, and eating disorder symptoms. Bean, et. al (2010) used two instruments to evaluate the

therapy, including the Eating Disorders Examination Questionnaire (EDE-Q) and the Beck Depression Inventory (BDI). In this treatment there are three phases to the process. Phase I has the treatment team focus on weight restoration and the patient does not move to the next phase until he or she reaches the recommended weight range. Phase II, on the other hand, encourages the patient to choose their own meal and family therapy sessions increase and emotional issues emerge. Phase III pushes the patient to look at maintenance of the eating disorder outside of treatment and make plans for the future. Bean, et. al (2010) concluded that both groups of patients (control and tested) improved in decreasing their symptom severity at discharge and symptoms were in the normal range at discharge. In addition, the Maudsley group of patients made larger improvements in decreasing severity of symptoms than the patient group with the regular treatment (Bean, et. al, 2010). The Maudsley approach has been shown to be successful for adolescents with AN (Le Grange, Binford, & Loeb, 2005). This type of therapy that focuses on family is one way to significantly decrease symptoms in patients. It is important to note that some therapies focus on increasing body weight to a healthy weight, whereas others look to change the thinking patterns in these individuals.

Feminist Therapy

One treatment that is not used very often is a feminist approach to therapy. Carolan, Bak, Hoppe-Rooney, and Burns-Jager (2009) developed and evaluated a program for women with eating disorders that focused on feminist principles. Like most researchers, the ones in this study acknowledge the presence of many different etiological factors in eating disorders, but that there were also many different treatment approaches. Carolan, et. al (2009) designed their therapy to focus on all aspects of the client,

including nutrition, cognitive, narrative, and family systems therapies, body dissatisfaction, eating issues, and empowerment with feminist principles. They used most of the mainstream treatment modalities while infusing their feminist principles that focused on empowerment for females. Carolan, et. al (2009) concluded that the best outcomes were for women with BN, and some of these women reduced their bingeing and purging from 50-100% by the end of treatment. In addition, clients became less likely to obsess about food and more likely to assertively address their concerns with their family during therapy (Carolan, et. al, 2009). Researchers from this study were very excited about results from their efforts, and were also vocal about praising the multidisciplinary approach to their therapy. Even with professional treatment, there is the possibility for relapse for any person with an eating disorder.

Summary

All of the treatment modalities listed earlier can be shown to have some amount of efficacy with patients. There is the boundary-control model, the cognitive behavior approach, Maudsley therapy, and the feminist approach. Within all these four, some have positives and negatives.

The boundary-control model is effective in setting boundaries for each individual. Individuals with eating disorders have a tough time with controlling their emotional regulation, which leads to the need to control their eating habits. (Blank & Latzer, 2004). This model also strives to fulfill the four basic needs (Belonging, Mastery, Pleasure, and Meaningfulness) for each individual in treatment (Blank & Latzer, 2004). This is a positive for each individual because the need to control their eating habits should subside when the four basic needs are met. The main drawback from this approach is that it had

not been tested on patients when it was written in 2004, but offers good insight into the psyche of adolescents with eating disorders.

Cognitive behavior therapy is effective in educating patients that their thoughts influence their behaviors and emotions negative or positive. With eating disorders, it is focused on changing incorrect thoughts related to weight, eating, and self-esteem. Treatment aims to engage the client, then look at thinking barriers for each patient, then put an emphasis on changing incorrect thoughts, and the final stage focuses on maintenance and relapse prevention (Byrne, et. al, 2011). This therapeutic approach has been proven successful through different studies, and is also effective in treating females with bulimia nervosa than anorexia nervosa (Cohen, et. al, 2004). The negative for this treatment is that it takes a long time to complete. It requires many therapy sessions, often requires hospitalization, and has a high dropout rate (Cohen, et. al, 2004).

Maudsley does an effective job of involving the family in the treatment of the adolescent. This therapy focuses on family-based interventions in which parents play an active role in the recovery of their child. This treatment looks at many different aspects of in the life of each patient, and consists of three phases. The treatment team focus on weight restoration first, then increase the family therapy sessions, and finally look inward at emotional issues and maintenance for the future. The Maudsley approach has been shown to be successful for adolescents with AN (Le Grange, Binford, & Loeb, 2005). It is important to note that this therapy focuses on increasing body weight to a healthy weight, whereas others look to change the thinking patterns in these individuals.

The feminist therapy approach is founded on feminist principles and is designed as a multidisciplinary treatment approach with empowerment taking a large focus. Like

most therapies, this one acknowledges the presence of many different etiological factors in eating disorders, but that there are many different treatment approaches. This approach is helpful especially for women with BN, and clients were able to address concerns with family after learning assertive communication skills (Carolan, et. al, 2009). One drawback from this approach is that it is only made for female clients, relies on feminist principles, and does not have the ability to be used for males with eating disorders.

Male Adolescents and Eating Disorders

The need to invest research into treatment with adolescents who have eating disorders has been increasing for the male gender. Much is known and has been studied about females and eating disorders, including causes, symptoms, and effective treatment styles. Researchers have much more experience looking at females' risk factors, characteristics, and treatments. This is primarily because the prevalence in males had not been addressed when the term eating disorder was first used. In the past couple of decades more research has been done regarding eating disorders and males, and most of it has been very helpful in the diagnosis and treatment for males.

Factors that Can Lead to Eating Disorders in Males

While males are diagnosed with eating disorders at a lower rate than females, they have risk factors that are just as important to investigate. Some risk factors that are reviewed below include puberty development, social influences, gender identity, and homosexuality. The first two of these can apply to both males and females in their development from adolescent to adult, but the next two are more likely to contribute to males developing an eating disorder.

Puberty Development

As male adolescents develop eating habits as children, they view their bodies differently than females. Boys during puberty try to increase their body mass and girls try to do the opposite or see gaining weight as negative (Gila, Castro, Cesena, & Toro, 2003). The male body ideal is different than the female ideal, which makes this concept so interesting. Males want to look larger in their shoulders, chest, and arms to fit the ideal body type that is shown through magazines, television, and the Internet. Male attractiveness is thus related to muscular strength (Furnham & Greaves, 1994). Males are also prone to overestimate the size of all parts of their body, including chest, biceps, and shoulders (Furnham & Greaves, 1994; Gila, et. al, 2003). This could indicate some cognitive issues with real body perception in males with anorexia, because it is not due to a perceptive disorder (Gila, et. al, 2003). These males with anorexia have a different view of their body compared to the general population. Males also were more concerned with having a more masculine shape rather than wearing small clothes (Muise, et. al, 2003). This is a different view than that of females with eating disorders. As males go through puberty, their brain develops the ideal body that they should have. This is developed primarily from social peers, media outlets, and sports.

Social Influences

As discussed with women, social influences can play a role in adolescent males developing eating disorders. In relation to female adolescents, males feel less social media pressure to maintain an ideal weight (Peterson, Paulson, & Williams, 2007). Males were shown, in this survey of 300 high school students, to acknowledge a lack of peer pressure surrounding eating habits. In addition, males were more likely to see media as an

influence on their dieting behaviors and saw media as a positive influence on gaining muscle mass while eating healthy (Pope, Olivardia, Borowicke, & Cohane, 2001; Halliwell & Harvey, 2006; Peterson, et. al, 2007). This approach concluded that media is not as influential on male eating habits or body dissatisfaction as on females. In the sample of 500 adolescents, each participant was surveyed and results indicate that females are more prone than males to developing eating disorders due to social influences (Halliwell & Harvey, 2006; Stice & Shaw, 2002). The male ideal image is also different than that of the female, as evidenced by large muscles and being very masculine. This is known as body dysmorphia in which individuals believe they are too small and work to become larger (Baird & Grieve, 2006). DeFeciani (2010) agreed with past findings that the more obsessed with body image the males become; the more likely they are to develop self-destructive behaviors (Baird & Grieve, 2006; Pope, et. al, 2001). Being obsessed with body image, due to media perceptions, can lead to engaging in unhealthy eating habits and lower body dissatisfaction (DeFeciani, 2010; Lorenzen, Grieve, & Thomas, 2004). Although media and social influences do not appear to play as large an influence on males as on females, it can still hinder the perception of body image for a male adolescent. Rodgers, Paxton, and Chabrol (2009) concluded that although males are not as affected by social pressures as females, these pressures are intensified for males with depression (Rodgers, et. al, 2009). Societal pressures still less affect males than females, but that is only one small difference in the development of eating disorders.

Another societal pressure that impacts the development of an eating disorder for males is the addition of competitive sports. As athletes get more competitive in sports, there is the added pressure to perform at a high level. Athletes also share certain

characteristics similar to those with an eating disorder. These psychological factors can include high levels of competitiveness, high emphasis on control, and perfectionist tendencies (Borgen & Corbin, 1987; Slade, Newton, Butler, & Murphy, 1991; Taub & Benson, 1992). These male athletes are at risk for eating disorders because they are exposed to weight pressures unique to the sport. Males tend to diet more defensively in sports that demand weight control while linking their lean physique with fitness for performance (Anderson, 1990; Sherman & Thompson, 2001). In addition, athletes are similar to those with eating disorders in that each group is concerned about the appearance of one's physique (Haase, Prapavessis, & Owens, 2002). These beliefs that a strict diet and lean physique will lead to more athletic success will focus more attention on eating habits. This heavy focus on eating habits can contribute to appearance of an eating disorder down the line for many athletes. While athletes struggle with dieting and pressures to be successful, other peers are more concerned about their own identity. Gender identity can be confusing for many adolescents and can influence how a male sees himself growing up.

Gender Identity

There are two major differences between males and females as factors in the development of eating disorders. Some studies show evidence of the prevalence of homosexuality in patients with eating disorders, while others have not found an increased incidence among males (Frasciello & Willard, 1995). Bassett (2002) studied 8 male patients with eating disorders in relation to their gender identity. Patients in this study were given a couple measures for gender identification, one unconscious and the other conscious. Despite the small sample for his study, Bassett (2002) concluded that the

measures used in his research did not show significant differences in the scores from the norms, but revealed significant sexual issues through the focused interview. Across the study, the patients were more likely to present their sexual issues in an interview rather than on a test or survey (Bassett, 2002). Bassett (2002) also postulated that the concept of gender identity conflict has been too widely used and been reported as a single complex of issues. There is not a defined area for gender identity or a test put together to accurately test this variable. Romeo (1994) believes sexual identity formation is important to recognizing males who are at risk for developing eating disorders. In addition, Romeo (1994) feels that society portrays one, strong male sexual identity figure in the media, and when this does not characterize the male in question, he will put himself through severe dieting and exercise to reach that ideal. Gender identity is still a topic that needs adequate research for males. Another topic that is much more prevalent in research and in society is homosexuality. Many researchers believe that homosexuality is a factor for males in developing eating disorders.

Homosexuality

While men develop eating disorders at a lower rate than females, homosexual men are at a higher risk than heterosexual men. There are studies that conclude that homosexual men are at a greater risk for developing an eating disorder because of cultural influences (Russell & Keel, 2002; Wichstrom, 2006). Boisvert and Harrell (2009) reveal that gay men have a culture that both emphasize a low weight and healthy physical appearance. Gay men may place a higher value on being thin in their attempt to be attractive to other men (Siever, 1994; Yelland & Tiggemann, 2003). The gay male body ideal typically emphasizes lower weight and muscular leanness (Yelland & Tiggemann,

2003). This culture can lead more gay men to restrict their eating and idealize a different body image than heterosexual men (Williamson & Hartley, 1998). Boisvert & Harrell (2009) concluded that gay men are at a higher risk for developing an eating disorder due to a higher degree of body shame. Body shame reflects the degree in which an individual internalizes body-related cultural expectations that are linked to the belief that achieving these standards is realistically possible, and the one is a bad person if these standards are not met (McKinley & Hyde, 1996). Hospers and Jansen (2005) postulated the role of gender role orientation, peer pressure, self-esteem, and body dissatisfaction are related to eating disorder symptoms. Additionally, there was evidence to support the conclusion that peer pressure perceptions for maintaining a low weight are another strong factor for gay men (Hospers & Jansen, 2005; Pope, Philips, & Olivardia, 2000). The leading factors that contribute to males developing eating disorders have been discussed at length. There exist a few treatment options for males with eating disorders, though not as many as for females.

Treatment Modalities and Males

Multidisciplinary Approach

Although there is not an extensive amount of research on treating males with eating disorders, the literature is sufficient is enough out there to get an idea of how to approach the disease. Romeo (1994) believes males should be approached similarly to females, in that treatment should require a team of treatment staff. This can include a dietician, social worker, physician and psychologist. Romeo (1994) also suggested several treatment options, including nutritional, family, and individual. Romeo (1994) also stated that males are more resistant to treatment. Frasciello and Willard (1995) agree

that individual therapy, family therapy, and nutritional counseling are beneficial in the treatment of adolescent males with eating disorders. When looking at the success of a multidisciplinary treatment approach with males, Weltzin, Weisensel, Cornella-Carlson, and Bean (2007) concluded some positive results. After looking at test results from 105 males with eating disorders, Weltzin, et. al (2007) compared these results to 35 female patients who underwent a similar treatment approach. This study was thorough in agreeing with past literature that a multidisciplinary treatment approach is effective in males with eating disorders (Eliot & Baker, 2001; Weltzin, et. al, 2007; Woodside & Kaplan, 1994). In addition, this study helped show parts of treatment that were especially helpful with the male patients. One such part was the addition of all-male groups, instead of groups with males and females present. This agreed with past research that this part of the treatment process allowed male patients to feel more comfortable discussing tough issues and topics without fear of judgment from females (Anderson, 1984; Weltzin, Weisensel, Franczyk, Burnett, Klitz, & Bean, 2005; Weltzin, et. al, 2007). Other results from this study showed that males with eating disorders had great success with a multidisciplinary approach while improving in several categories. Male participants in this study were able to gain weight into the healthy range, become less concerned with weight, lose their drive for thinness, and be more satisfied with their body image (Weltzin, et. al, 2007). Males were also more likely to achieve success in treatment if they stayed in residential treatment for a longer period of time (Weltzin, et. al, 2007; Woodside & Kaplan, 1994). Eliot and Baker (2001) followed-up with past patients at an outpatient treatment center to compare males and females with eating disorders. Their results agree with past research that suggests males and females are very similar in long-

term outcomes after finishing treatment (Burns & Crisp, 1985; Eliot & Baker, 2001; Woodside, 2002). Research has shown that the multidisciplinary approach is effective in the treatment of adolescent males with eating disorders, can be just as effective with males as it is with females, and has positive long-term outcomes after treatment has finished.

The review of literature on eating disorders in male and female adolescents and adults shows differences and similarities between the genders on factors that contribute to developing the disease, characteristics of those with an eating disorder, and treatment approaches that have been shown to be effective. Based on a review of the literature on eating disorders between both genders, the research question for this study is: What are the similarities and differences between genders in treating adolescents with eating disorders? To study this question, this researcher completed several quantitative surveys of eating disorder therapists around the United States. Each survey consisted of questions focused on answering the research question.

Conceptual Framework

For this research study this researcher will use systems theory for my conceptual framework. As many different systems affect every individual, it is important to realize the impact of these systems and tailor a treatment plan to the individual. A system can be defined as an organized thing that is made up of parts that interact with each other in a different way than their interactions with other entities (Miley, O'Melia, & Dubois, 2010). Systems essentially interact with each other in different ways with different influences and patterns. There are also subsystems, which are smaller parts of each larger system (Miley, et. al, 2010). In a family system, the children and parents are examples of subsystems. In each system there is also an environment, which "influences and provides the context for the systems functioning within it" (Miley, et. al, 2010, p. 35). All systems have subsystems and environments, which act as fluid influences on each other.

Another important concept of systems theory is the presence of different dimensions. There are dimensions of structure, interaction, biopsychosocial influences, and culture. Structure looks at how each system is organized, interaction reviews how each system responds to its parts and other systems, biopsychosocial looks at the different characteristics of people within systems, and the cultural view focuses on ethnicity and culture as related to human functioning (Miley, et. al, 2010). Each system has a dynamic affect on each other system, and this can be related to people easily. The research on eating disorders suggests there were many factors for both males and females that related back to the different systems that affected the thinking and actions of individuals with eating disorders. Each person diagnosed with an eating disorder dealt with the influences of many systems of all sorts of dimensions. This had a lasting affect on these people and

influenced how each responded to treatment. Treatments have also become more dynamic in a response to different systems in the life of a client.

Personal Bias

As with any research study, it is important to account for potential biases, including researcher bias. Prior to this study, this researcher did not have much experience with eating disorders. This researcher did have a few friends in college that had eating disorders, one of whom was male. This was one of the main reasons this researcher decided to pursue a research project looking into treatment differences between genders. Having friends with eating disorders is a tough process to watch, especially when friends do not think they have a disease. This is the main bias in the study, as this researcher has strong emotions about eating disorders and this can affect how the research results are viewed. An advantage is that professionals in the field were surveyed electronically reducing the potential for emotional biases affecting the data collection process.

Another personal bias is the nature of the research survey questions and the data analysis. This researcher designed the questionnaire and without previously testing the reliability and validity of the instrument, there is likely instrument bias affecting the results. This researcher compared findings to past research, so in the comparison there is some amount of bias towards personal assumptions about eating disorders. This can cause this researcher to assume there will be significant findings within the data even if it does not appear to be significant to others.

Methods

Research Design

The research design for this study originally planned on using a qualitative approach, but this was changed to a quantitative design after an inability to find participants. The interview questions were switched survey questions using Likert scale and multiple-choice questions. Quantitative survey provided some answers to the research question of this study. Each survey took about 4 minutes for each participant to complete, and took place with eating disorder therapists around the Continental United States. These therapists serve clients who suffer from some form of an eating disorder, and use a variety of methods for treatment.

Sample

The sample for this project was taken from a list of licensed therapists that work with eating disorders in the Continental United States. The snowball sampling technique was used for finding participants in that participants were acquired through word of mouth (Monette, et. al, 2011). The committee members for this project referred participants to this researcher and more participants were found through the National Association of Anorexia Nervosa and Associated Disorders (ANAD) and the National Eating Disorders Association (NEDA). The therapists who were surveyed have experience working with both male and female adolescents in order to give useful responses to all questions. This researcher recruited 8 participants for this study that had between 15 and 28 years of experience working with female and male adolescents with eating disorders. The licenses for each participant varied as well, and included two participants with a LCSW, two dieticians, one medical doctor, one LPC and LMFT, one

RD and LDN, and one LMHC. Participants were found from around the country and many were found through NEDA.

Protection of Human Subjects

Recruitment process

To acquire participants for this study this researcher originally intended on sending e-mails to eating disorder therapists around the Minneapolis/St. Paul area. After many conversations with therapists through e-mail this researcher was unable to find any therapists with the time to sit down for an interview for this study. Many said they were interested but simply did not have the time. The decision was made to change the interview questions to survey questions by making them multiple choice or have Likert scale answers. A protocol change was submitted to the St. Catherine Institutional Review Board to switch the type of research from qualitative to quantitative, which was approved. After the protocol change was approved, this researcher recruited participants from different national organizations by way of a national list-serv of therapists.

To acquire the contact list for participants this researcher sent e-mails to ANAD and NEDA to request permission to access a list-serv of members that work with adolescents with eating disorders. The e-mails contained the statement included in Appendix B.

A brief list-serv was obtained from NEDA, and a brief e-mail was sent to each possible participant that fit the criteria from above. Each e-mail sent to possible participants contained the statement included in Appendix C.

Confidentiality & Anonymity

To ensure confidentiality for all participants, this researcher did not use any names of participants in any part of the project. Data was collected using Qualtrics, an online survey website that allowed for the data to be stored confidentially. All raw data was downloaded from the website and saved on this researcher's computer and no names were included. Only this researcher was able to access the data while conducting the study. All data from this project will be destroyed on June 1, 2013.

Protocol for ensuring informed consent

To ensure informed consent, all participants were provided an informed consent form that describes the research study, risks, benefits, and asked the participant if he/she understands the consent form. Participants were offered an opportunity to ask any questions regarding the study, its risks and benefits, as well expectations of participants in the initial e-mail to acquire participants. Study participants were notified that by taking the online survey that this was an indication that their consent was given to participate in the study. At the bottom of the e-mail sent to all possible participants it was noted that the survey was strictly voluntary and that any participant could stop at any point.

Data collection

Data was collected from 8 survey participants. Each survey was saved in the Qualtrics system until it was downloaded, by this researcher, to analyze. All participants were asked the revised survey questions in Appendix A. All non-demographic questions were intended to answer the research question of: What are the similarities and differences between female and male adolescents in the treatment of eating disorders?

This helps the validity for this research project, because all questions are measuring the main research question for this study.

Data analysis

Descriptive statistic measures were used to analyze the data from this study. This type of statistics help in organizing, summarizing, and interpreting the body of data (Monette, Sullivan, & Dejong, 2010). This approach was used because of the exploratory nature of this study into treatment differences between male and female adolescents with eating disorders. Descriptive statistics allows this study to organize and present the data without making generalizations to the larger population of those with eating disorders.

Findings

Frequency Distribution - “Percentage of Male Adolescent Clients”

The first variable on the survey measured the percentage of male adolescent clients at the respondents’ agencies. The variable took the numerical options of “0%-19%,” “20%-40%,” “41%-60%,” “61%-80%,” and “81%-100%.” The research question for the study was: What is the approximate percentage of male clients at your agency? The findings of this study in Table 1 show that all eight indicated that there are less than 20% of male adolescent clients being treated for eating disorders at their respective agencies.

Table 1. Percentage of Male Adolescent Clients

	Frequency	Percent
Valid 0%-19%	8	100.0

Frequency Distribution - “Common Factors Contributing to Eating Disorders in Male Adolescents”

The second variable on the survey measured the common factors that contribute to eating disorders in male clients. The variable had the options of “family life,” “social influences,” “puberty,” “homosexuality and gay culture,” “genetic factors,” “a combination of factors,” and “other.” Respondents had the option of choosing more than one answer. The research question for this study was: What are the most common factors contributing to eating disorders in male adolescents? The findings of this study in Table 2 show that out of eight respondents, 88% (n=7) indicated that a combination of factors contributed to eating disorders in male adolescents. These findings indicate that many of the respondents (n=7) thought a combination of factors contributes to eating disorders in male adolescents.

Table 2. Common Factors Contributing to Eating Disorders in Male Adolescents

	Frequency	Percent
Family Life	3	38
Social Influences	3	38
Puberty	2	25
Homosexuality and Gay Culture	2	25
Genetic Factors	1	12
A Combination of Factors	7	88

Frequency Distribution - “Factors’ Influence on Treatment Options for Male Adolescents”

The third variable on the survey measured the respondents’ opinion on the amount of influence of the contributing factors on treatment options for male adolescents. The variable was a Likert scale and had the options of “not at all,” “very little,” “somewhat,” “much,” and “to a great extent.” The research question for this study was: How much do these factors influence the treatment options for male adolescents? The findings of this study in Table 3 show that out of eight respondents, 50% (n=4) indicated that the factors to developing an eating disorder affect the treatment options only somewhat with male adolescents. Another 38% (n=3) of respondents indicated that the factors to developing an eating disorder affect the treatment options to a great extent with male adolescents. These findings indicate that half the respondents feel that the contributing factors somewhat influenced the treatment options for the male adolescent client.

Table 3. Factors’ Influence on Treatment Options for Male Adolescents

	Frequency	Percent	Cumulative Percent
Somewhat	4	50	50
Much	1	12	62
To a Great Extent	3	38	100
Total	8	100	100

Frequency Distribution - “Treatment Approaches for Male Adolescents”

The fourth variable on the survey measured the respondents’ treatment options for male adolescents at their respective agencies. The variable had the options of “boundary-control model,” “Maudsley therapy,” “cognitive behavior therapy,” “multidisciplinary approach,” “family therapy,” “interpersonal therapy,” and “other.” Respondents had the option of choosing more than one answer. The research question for this study was: What are the treatment approaches for male adolescents at this agency? The findings of this study in Table 4 show that out of eight respondents, 75% (n=6) indicated that some form of family therapy was used in the treatment of male adolescents. Five respondents (63%) indicated that some form of cognitive behavior therapy, multidisciplinary approach, or interpersonal therapy were used in the treatment of male adolescents.

Table 4. Treatment Approaches for Male Adolescents

	Frequency	Percent
Boundary-Control Model	0	0
Maudsley Therapy	2	25
Cognitive Behavioral Therapy	5	63
Multidisciplinary Approach	5	63
Family Therapy	6	75
Interpersonal Therapy	5	63
Other	1	13

Frequency Distribution - "Treatment Success Rate for Male Adolescents"

The fifth variable on the survey measured the respondents' opinion on the treatment success for male adolescents. The variable was a Likert scale and had the options of "never," "rarely," "sometimes," "very often," and "always." The research question for this study was: How successful is the treatment for male adolescents at this agency? The findings of this study in Table 5 show that out of eight respondents, 50% (n=4) indicated that the treatment sometimes works with male adolescents with eating disorders. Another three (37.5%) respondents indicated that the treatment approaches often work with male adolescents. These findings indicate the majority (n=7) of respondents indicated the treatment approach sometimes or often works with the male adolescents at their agencies.

Table 5. Treatment Success Rate for Male Adolescents

	Frequency	Percent	Cumulative Percent
Sometimes	4	50	50
Often	3	38	88
All of the Time	1	12	100
Total	8	100	100

Frequency Distribution - “Most Effective Treatment for Male Adolescents”

The sixth variable on the survey measured the respondents’ opinion on the most effective treatment approach for male adolescents. The variable had the options of “boundary-control model,” “Maudsley therapy,” “cognitive behavior therapy,” “multidisciplinary approach,” “family therapy,” “interpersonal therapy,” and “other.” The research question for this study was: In your opinion, what is the most effective way to treat eating disorders in male adolescent clients? The findings of this study in Table 6 show that out of eight respondents, 63% (n=5) indicated that some form of a multidisciplinary approach is the most effective way to treat male adolescents. Another three (38%) indicated that some form of cognitive behavior therapy is the most effective way to treat male adolescents. These findings show that the majority of the sample (n=5) views the multidisciplinary approach as the most effective way to treat male adolescents with eating disorders.

Table 6. Most Effective Treatment for Male Adolescents

	Frequency	Percent	Cumulative Percent
Cognitive Behavioral Therapy	3	38	38
Multidisciplinary Approach	5	62	100
Total	8	100	100

Frequency Distribution - “Family Involvement in Treatment of Male Adolescents”

The seventh variable on the survey measured how much the family is involved with the treatment of male adolescents. The variable was a Likert scale and had the options of “never,” “very rarely,” “rarely,” “sometimes,” “often,” and “all of the time.” The research question for this study was: How much is the family involved in the treatment of male adolescents at your agency? The findings of this study in Table 7 show that out of eight respondents, 50% (n=4) indicated that the family is often involved with male adolescents with eating disorders. Another two (25%) respondents indicated that family is either involved all of the time with male adolescents or only sometimes. These findings indicate the majority of respondents (n=6) indicated the family is often or always involved in the treatment approach with the male adolescents at their agencies.

Table 7. Family Involvement in Treatment of Male Adolescents

	Frequency	Percent	Cumulative Percent
Sometimes	2	25	25
Often	4	50	75
All of the Time	2	25	100
Total	8	100	100

Frequency Distribution - “Barriers to Treatment for Male Adolescents”

The eighth variable on the survey measured the barriers to treatment for male adolescents at the respondents’ respective agencies. The variable had the options of “scheduling barriers,” “client resistance,” “parent disagreement,” “inconsistent messages from authority figures,” and “other.” Respondents had the option of choosing more than one answer if they wanted. The research question for this study was: What are the barriers to treatment for male adolescents at your agency? The findings of this study in Table 8 show that out of eight respondents, 75% (n=6) indicated that inconsistent messages from authority figures (parents, coaches, therapists, etc.) was the main barrier to treatment of male adolescents. Four (50%) respondents indicated that some form client resistance was a barrier to treatment of male adolescents.

Table 8. Barriers to Treatment for Male Adolescents

	Frequency	Percent
Scheduling Barriers	0	0
Client Resistance	4	50
Parent Disagreement	3	38
Inconsistent Messages	6	75
Other	2	25

Frequency Distribution - “Common Factors Contributing to Eating Disorders in Female Adolescents”

The ninth variable on the survey measured the common factors that contribute to eating disorders in female clients. The variable had the options of “family life,” “social influences,” “puberty,” “homosexuality and gay culture,” “genetic factors,” “a combination of factors,” and “other.” Respondents had the option of choosing more than one answer if they wanted. The research question for this study was: What are the most common factors contributing to eating disorders in female adolescents? The findings of this study in Table 9 show that all eight respondents indicated that a combination of factors contributed to eating disorders in female adolescents. Out of eight respondents, 50% (n=4) chose social influences as a contributing factor to the cause of eating disorders in female adolescents. These findings indicate that the entirety of the sample (n=8) thought a combination of factors contributes to eating disorders in female adolescents.

Table 9. Common Factors Contributing to Eating Disorders in Female Adolescents

	Frequency	Percent
Family Life	3	38
Social Influences	4	50
Puberty	2	25
Genetic Factors	2	25
A Combination of Factors	8	100
Other	1	12

Frequency Distribution - “Factors’ Influence on Treatment Options for Female Adolescents”

The tenth variable on the survey measured the respondents’ opinion on the amount of influence of the contributing factors on treatment options for female adolescents. The variable was a Likert scale and had the options of “not at all,” “very little,” “somewhat,” “much,” and “to a great extent.” The research question for this study was: How much do these factors influence the treatment options for female adolescents? The findings of this study in Table 10 show that out of eight respondents, half (n=4) indicated that the factors to developing an eating disorder affect the treatment options much with female adolescents. Three (37.5%) respondents indicated that the factors to developing an eating disorder affect the treatment options to a great extent with female adolescents. These findings indicate that the majority of respondents (n=7) indicated that the contributing factors had a great deal of influence on how the treatment options were developed for the female adolescent client.

Table 10. Factors’ Influence on Treatment Options for Female Adolescents

	Frequency	Percent	Cumulative Percent
Somewhat	1	12	12
Much	4	50	62
To a Great Extent	3	38	100
Total	8	100	100

Frequency Distribution - “Treatment Approaches for Female Adolescents”

The eleventh variable on the survey measured the respondents’ treatment options for female adolescents at their respective agencies. The variable had the options of “boundary-control model,” “Maudsley therapy,” “cognitive behavior therapy,” “multidisciplinary approach,” “family therapy,” “interpersonal therapy,” and “other.” Respondents had the option of choosing more than one answer if they wanted. The research question for this study was: What are the treatment approaches for female adolescents at this agency? The findings of this study in Table 11 show that out of eight respondents, 75% (n=6) indicated that some form of family therapy was used in the treatment of female adolescents. Five (63%) indicated that some form of cognitive behavior therapy, multidisciplinary approach, or interpersonal therapy were used in the treatment of female adolescents. These findings indicate that the majority of the sample uses a variety of methods (n=5) to treat female adolescents with eating disorders.

Table 11. Treatment Approaches for Female Adolescents

	Frequency	Percent
Maudsley Therapy	2	25
Cognitive Behavioral Therapy	5	63
Multidisciplinary Approach	5	63
Family Therapy	6	75
Interpersonal Therapy	5	63
Other	1	13

Frequency Distribution - “Treatment Success Rate for Female Adolescents”

The twelfth variable on the survey measured the respondents’ opinion on the treatment success for female adolescents. The variable was a Likert scale and had the options of “never,” “rarely,” “sometimes,” “very often,” and “always.” The research question for this study was: How successful is the treatment for female adolescents at this agency? The findings of this study in Table 12 show that out of eight respondents, 63% (n=5) indicated that the treatment often works with female adolescents with eating disorders. A single (13%) respondent indicated that the treatment approaches always works with female adolescents. These findings indicate the majority of respondents (n=5) feel their treatment approach often works with the female adolescents at their agencies.

Table 12. Treatment Success Rate for Female Adolescents

	Frequency	Percent	Cumulative Percent
Sometimes	2	25	25
Often	5	63	88
All of the Time	1	12	100
Total	8	100	100

Frequency Distribution - “Most Effective Treatment for Female Adolescents”

The thirteenth variable on the survey measured the respondents’ opinion on the most effective treatment approach for female adolescents. The variable had the options of “boundary-control model,” “Maudsley therapy,” “cognitive behavior therapy,” “multidisciplinary approach,” “family therapy,” “interpersonal therapy,” and “other.” The research question for this study was: In your opinion, what is the most effective way to treat eating disorders in female adolescent clients? The findings of this study in Table 13 show that out of eight respondents, 63% (n=5) indicated that some form of a multidisciplinary approach is the most effective way to treat female adolescents. Three respondents (38%) indicated that some form of cognitive behavior therapy is the most effective way to treat female adolescents. These findings indicate that the majority of the sample (n=5) views the multidisciplinary approach as the most effective way to treat female adolescents with eating disorders.

Table 13. Most Effective Treatment for Female Adolescents

	Frequency	Percent	Cumulative Percent
Cognitive Behavioral Therapy	3	38	38
Multidisciplinary Approach	5	62	100
Total	8	100	100

Frequency Distribution - “Family Involvement in Treatment of Female Adolescents”

The fourteenth variable on the survey measured how much the family is involved with the treatment of female adolescents. The variable was a Likert scale and had the options of “never,” “very rarely,” “rarely,” “occasionally,” “frequently,” and “always.” The research question for this study was: How much is the family involved in the treatment of female adolescents at your agency? The findings of this study in Table 14 show that out of eight respondents, half (n=4) indicated that the family is often involved with female adolescents with eating disorders. Two (25%) respondents indicated that family is either involved all of the time with female adolescents or only sometimes. These findings indicate the majority of respondents (n=6) indicated the family is often or always involved in the treatment approach with the female adolescents at their agencies.

Table 14. Family Involvement in Treatment of Female Adolescents

	Frequency	Percent	Cumulative Percent
Sometimes	2	25	25
Often	4	50	75
All of the Time	2	25	100
Total	8	100	100

Frequency Distribution - “Barriers to Treatment for Female Adolescents”

The fifteenth variable on the survey measured the barriers to treatment for female adolescents at the respondents’ respective agencies. The variable had the options of “scheduling barriers,” “client resistance,” “parent disagreement,” “inconsistent messages from authority figures,” and “other.” Respondents had the option of choosing more than one answer if they wanted. The research question for this study was: What are the barriers to treatment for female adolescents at your agency? The findings of this study in Table 15 show that out of eight respondents, 75% (n=6) indicated that some form of client resistance was the main barrier to treatment of female adolescents. Five respondents (63%) indicated inconsistent messages from authority figures (parents, coaches, therapist, etc.) was a barrier to treatment of female adolescents.

Table 15. Barriers to Treatment for Female Adolescents

	Frequency	Percent
Scheduling Barriers	0	0
Client Resistance	6	75
Parent Disagreement	2	25
Inconsistent Messages	5	63
Other	2	25

Frequency Distribution - “Similar Factors Contributing to Eating Disorders”

The sixteenth variable on the survey measured the similar common factors that contribute to eating disorders in male and female adolescent clients. The variable had the options of “family life,” “social influences,” “puberty,” “homosexuality and gay culture,” “genetic factors,” and “other.” Respondents had the option of choosing more than one answer if they wanted. The research question for this study was: Are there any similar factors contributing to eating disorders in both genders? The findings of this study in Table 16 show that out of eight respondents, 88% (n=7) indicated that family life, social influences, and genetic factors were similar factors that contributed to eating disorders in both male and female adolescents. Six respondents (75%) indicated that puberty was a similar factor that contributed to eating disorders in both male and female adolescents. These findings show that the majority of the sample (n=7) thought family life, social influences, and genetic factors were similar factors that contributed to eating disorders in both male and female adolescents.

Table 16. Similar Factors Contributing to Eating Disorders

	Frequency	Percent
Family Life	7	88
Social Influences	7	88
Puberty	6	75
Homosexuality and Gay Culture	1	12
Genetic Factors	7	88

Frequency Distribution - “Comparison of Treatment Approaches Between Genders”

The seventeenth variable on the survey measured the respondents’ opinion on the comparison of treatment approaches between genders. The variable was a Likert scale and had the options of “not at all similar,” “slightly similar,” “somewhat similar,” “very similar,” and “a great deal similar.” The research question for this study was: How do the treatment approaches for female adolescents compare to those for male adolescents at this agency? The findings of this study in Table 17 show that out of eight respondents, 75% (n=6) indicated that the treatment approaches for female adolescents are very similar to the treatment approaches for male adolescents. A single (13%) respondent indicated that the treatment approaches female adolescents are a great deal similar to the treatment approaches for male adolescents. These findings indicate the majority of respondents (n=7) felt the treatment approaches for both genders are very similar.

Table 17. Comparison of Treatment Approaches Between Genders

	Frequency	Percent	Cumulative Percent
Somewhat similar	1	12.5	12.5
Very similar	6	75	87.5
A great deal similar	1	12.5	100
Total	8	100	100

Frequency Distribution - “Individualized Treatment”

The eighteenth variable on the survey measured if the respondent individualized treatment for the clients at their agency. The variable had two answer options of “yes” and “no.” The research question for this study was: Do you individualize treatment for each client? The findings of this study in Table 18 show that all eight respondents (100%) indicated that the treatment is individualized for each client at their agencies.

Table 18. Individualized Treatment

	Frequency	Percent
Yes	8	100.0

Discussion

This study used a systems theory approach to look at the respective influences on clients and treatment and collected descriptive quantitative data on the possible differences and similarities between genders in treating adolescents with eating disorders. There have been few studies to compare the two genders and their respective treatment modalities. This study collected data on treatment approaches, factors that cause eating disorders, and different systems that affect treatment of clients to add useful data to the depth of knowledge on eating disorders.

Females

In surveying the factors that contribute to eating disorders in female adolescents, this study found that a combination of factors was the predominant choice from all respondents. This study is consistent with past literature that multiple factors contribute to the eating disorder in a female adolescent. Several researchers agree that family dysfunction is found in many female adolescents with eating disorders (Benninghoven, Schneider, Strack, Reich, & Cierpka, 2003; Wisotsky, Dancyger, Fornari, Katz, Wisotsky, & Swencionis, 2003; Latzer, et. al, 2009). Others still contend that social influences are increasingly leading female adolescents to develop eating disorders (Carlson Jones, 2001; Lin & Kulik, 2002; Trottier & Herman, 2007). Puberty has also been widely viewed as having a significant contributing factor to eating disorders in female adolescents due to the increased concern with body image (Attie & Brooks-Gunn, 1989; Levine & Smolak, 1992; Levine, et. al, 1994; Smolak, et. al, 1996). These researchers all mention that several factors should be taken into account when determining the cause of an eating disorder in female adolescents.

This study surveyed therapists with extensive experience with different treatment options for adolescents with eating disorders, which have been studied at length in the past. The majority of respondents in this study indicated that they used a variety of treatment approaches with female adolescent clients, including cognitive behavioral therapy, family therapy, and a multidisciplinary approach. Past research has indicated that cognitive behavioral therapy is very effective with female adolescents with eating disorders and keeping symptoms in remission in follow-up surveys or interviews (Byrne, et. al, 2011; Cohen, et. al, 2004). Family therapy was also mentioned as being a particularly helpful component of Maudsley therapy while focusing on family-based interventions (Le Grange, Binford, & Loeb, 2005). Results from this study were steadily consistent with past research on female adolescents with eating disorders, from contributing factors to treatment options.

Males

In this study, practitioners identified that the factors found in male adolescents contributing to eating disorders were puberty, social influences, and a combination of factors. Past literature is consistent with the findings from this study on contributing factors for eating disorders in adolescent males. As written earlier, females are susceptible to eating disorders during puberty development. Males are also affected by the period of puberty development as it relates to eating disorders (Furnham & Greaves, 1994). Several studies found that even though males view their bodies differently than females at the time of puberty, they were very concerned with developing a masculine shape (Furnham & Greaves, 1994; Gila, et. al, 2003). The research stays consistent with the data from this survey that social influences are factors in contributing to eating

disorders in adolescent males. Men are prone to societal influences, and an obsession with body image due to media perceptions can lead to body dissatisfaction and eating disorders (DeFeciani, 2010; Lorenzen, Grieve, & Thomas, 2004). As with many adolescent males, a combination of factors can contribute to an eating disorder. While an eating disorder can be caused by many different factors, it is often hard to determine the exact factor that led to the eating disorder. Research stays consistent with this study that many factors can lead to an eating disorder. Muise, et. al (2003) postulated that many influences in the life of an adolescent male can lead to an eating disorder.

In male adolescents with eating disorders several researchers indicated that a multidisciplinary approach was most useful, which is consistent with the findings of this study. These studies reported that a treatment plan that included nutrition education, individual and family therapies was very beneficial for male adolescents with eating disorders (Eliot & Baker, 2001; Weltzin, et. al, 2007; Woodside & Kaplan, 1994). Males involved in this treatment made significant progress in several areas, including gaining weight into the healthy range, becoming less concerned with weight, losing their drive for thinness, and becoming more satisfied with their body image (Weltzin, et. al, 2007).

Similarities and Differences Between Genders

One interesting note from this survey is that the majority of respondents reported that their treatment approaches across genders was somewhat similar, very similar, or a great deal similar. In addition, five respondents indicated that the multidisciplinary approach was the most effective treatment with both female and male adolescents with eating disorders. These findings agree with past studies that determined both males and female adolescents show very similar outcomes in long-term treatment using a

multidisciplinary approach (Burns & Crisp, 1985; Eliot & Baker, 2001; Woodside, 2002). Respondents from this study indicated the multidisciplinary approach was the most common treatment approach for both males and females, and has been shown to be very effective long-term with these populations.

Another similarity across genders found in this study that is consistent with past literature is the inclusion of family in the treatment process. Half the respondents (n=4) indicated that the family was often involved with the treatment of both female and male adolescents at their agencies and 2 respondents indicated that the family was involved in all treatment aspects of clients at their agencies. This data is consistent with past studies that determined that when the family is involved the treatment results are beneficial for the client (Eliot & Baker, 2001; Weltzin, et. al, 2007; Woodside & Kaplan, 1994). While many similarities were found between genders in this study, there were slight differences to be found.

One slight difference found in the data studied the success rate of treatment for each gender according to the respondents. A majority of respondents (n=5) indicated that treatment was often successful with female adolescents, and only a few (n=3) felt that treatment was often successful with male adolescents. This slight difference in results could be due to a couple reasons. The first reason is a possible heightened resistance from male clients. Romeo (1994) indicated that males are more resistant to treatment than females because it was more of a stigmatized disease for males. Bean, et. al (2008) suggested that males tended to stay longer in residential treatment programs by an average of 30 days, which he attributed to higher resistance at the start of treatment. The second reason for a difference in results could be therapist inexperience with male clients.

Females are more frequently treated for eating disorders, and it would be understandable if therapists were more experienced in treating females than with males. This inexperience could lead to a lower success rate with male clients.

Implications

From the results of this study, implications can be made across practice, policy, and future research. This study adds more knowledge to the practice of treating eating disorders in adolescents. It does so by showing that this small sample of respondents indicated that treatment for both genders is individualized but still similar in approach. In treating each client the therapists look to his or her past and the majority use a multidisciplinary approach for treatment. The majority of respondents also indicated that they believe their treatment methods often work with adolescents with eating disorders, which is backed up by research. Results from this study will help show future practitioners that many different approaches work with clients and that similar treatment modalities can be used for both male and female adolescents.

This study lends evidence to the need for policies helping adolescents with eating disorders. One policy that aims to close the gap in research about eating disorders is the FREED Act. This policy is structured to not only improve research on eating disorders but also train health and school professionals to appropriately identify and respond to eating disorders and require insurance companies to reimburse for eating disorders treatment on par with physical illnesses (Eating Disorders Coalition, 2012). Policies for helping those with eating disorders are few, and the FREED Act would be a step in the right direction.

Future research will be able to use this study to add evidence to the beliefs that males and females are amenable to similar treatment approaches. Researchers should continue to look at the impact of different systems on clients and their recovery as well as more general research on males. The studies of males with eating disorders are not as

numerous and not as thorough as the research on females. Further research should be done on other components of clients with eating disorders, such as race. Most research on eating disorders has been done on Caucasian women, and research should be expanded to cover other demographics with eating disorders. This study adds knowledge on both genders that can be used to show how successful is treatment from the perspective of the therapist.

Strengths and Limitations

This study had both strengths and limitations.. This study surveyed practitioners on their work in this field, and as experts, their knowledge added value to the scholarship on eating disorders. All respondents had at least 15 years of experience treating adolescents with eating disorders. Another strength is having committee members look at the data found from the survey answers. This allowed multiple people to look at the themes and agree on what is important to include in the findings. There is also one professional in the field of eating disorders on this committee and another who conducted past research on eating disorders, which allowed them to lend their professional opinion to all parts of the project.

There are numerous limitations to this study. All data can be affected by the bias of this researcher in the data analysis portion of the project. Another limitation is the small sample size and low response rate for the survey. A greater sample size can help reinforce the data and lead to a better ability to generalize the results to a larger population. This researcher did not define the variable “multidisciplinary approach” prior to sending out the survey, so each respondent could interpret the variable differently. Due to time constraints for collecting data, this researcher did not test the reliability or validity of the survey questions. Testing for both reliability and validity would lead to more consistent results from respondents. Even with the limitations, there are many positives to take from this study of gender differences and similarities in treating adolescents with eating disorders.

Conclusion

The aim of this study was to gain knowledge on the differences and similarities between genders in treating eating disorders from the perspective of the therapist. Past literature provided insight into the most common contributing factors to an eating disorder, effective treatment modalities, and how genders compare in these aspects. Data from this study helped confirm many commonalities between genders and showed that therapists believe both genders are amenable to similar treatment approaches. Therapists from this study believe a multidisciplinary approach to treatment with both genders can be very effective while the differences between genders with eating disorders are few. Respondents indicated that they use similar treatment approaches with both genders and found their treatments to be mostly effective. This study lends knowledge to the great amount of research on adolescents with eating disorders.

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Appendix A – Eating Disorder Treatment Survey Questions

1. What is the approximate percentage of male clients at your agency?
 - a. <20%
 - b. 20-40%
 - c. 41-60%
 - d. 61-80%
 - e. 81-100%
2. What are the most common factors contributing to eating disorders in female adolescents?
 - a. Family life
 - b. Social Influences (media, peers, etc.)
 - c. Puberty
 - d. Homosexuality and gay culture
 - e. Genetic factors
 - f. A combination of factors
 - g. Other
3. How much do these factors influence the treatment options for female adolescents?

Likert scale

 - 1=Not at all
 - 2=Very Little
 - 3=Somewhat
 - 4=Much
 - 5=To a Great Extent
4. What are the most common factors contributing to eating disorders in male adolescents?
 - a. Family life
 - b. Social Influences (media, peers, etc.)
 - c. Puberty
 - d. Homosexuality and gay culture
 - e. Genetic factors
 - f. A combination of factors
 - g. Other
5. How much do these factors influence the treatment options for male adolescents?

Likert scale

 - 1=Not at all
 - 2=Very Little
 - 3=Somewhat
 - 4=Much
 - 5=To a Great Extent
6. Are there any similar factors contributing to eating disorders in both genders?
 - a. Family life
 - b. Social Influences (media, peers, etc.)
 - c. Puberty
 - d. Homosexuality and gay culture
 - e. Genetic factors
 - f. Other

7. What are the treatment approaches for female adolescents at this agency?
 - a. Boundary-Control Model
 - b. Maudsley Therapy
 - c. Cognitive behavior therapy
 - d. Multidisciplinary approach
 - e. Family therapy
 - f. Interpersonal therapy
 - g. Other
8. What are the treatment approaches for male adolescents at this agency?
 - a. Boundary-Control Model
 - b. Maudsley Therapy
 - c. Cognitive behavior therapy
 - d. Multidisciplinary approach
 - e. Family therapy
 - f. Interpersonal therapy
 - g. Other
9. How successful is the treatment for male adolescents at this agency?

Likert Scale

 - 1=Never
 - 2=Rarely
 - 3=Sometimes
 - 4=Very Often
 - 5=Always
10. How successful is the treatment for female adolescents at this agency?

Likert Scale

 - 1=Never
 - 2=Rarely
 - 3=Sometimes
 - 4=Very Often
 - 5=Always
11. How do the treatment approaches for female adolescents compare to those for male adolescents at this agency?

Likert Scale

 - 1=Not at all similar
 - 2=Slightly similar
 - 3=Somewhat similar
 - 4=Very Similar
 - 5=A Great deal similar
12. Do you individualize treatment for each client?

Yes or No question
13. In your opinion, what is the most effective way to treat eating disorders in male adolescent clients?
 - a. Boundary-Control Model
 - b. Maudsley Therapy
 - c. Cognitive behavior therapy
 - d. Multidisciplinary approach

- e. Family therapy
 - f. Interpersonal therapy
 - g. Other
14. In your opinion, what is the most effective way to treat eating disorders in female adolescent clients?
- a. Boundary-Control Model
 - b. Maudsley Therapy
 - c. Cognitive behavior therapy
 - d. Multidisciplinary approach
 - e. Family therapy
 - f. Interpersonal therapy
 - g. Other
15. How much is the family involved in the treatment of male adolescents at your agency?
- Likert Scale
- 1=Never
 - 2=Very Rarely
 - 3=Rarely
 - 4=Occasionally
 - 5=Frequently
 - 6= Always
16. How much is the family involved in the treatment of female adolescents at your agency?
- Likert Scale
- 1=Never
 - 2=Very Rarely
 - 3=Rarely
 - 4=Occasionally
 - 5=Frequently
 - 6= Always
17. What are the barriers to treatment for male adolescents at your agency?
- a. Scheduling barriers
 - b. Client resistance
 - c. Parent disagreement
 - d. Inconsistent messages from authority figures (parents, coaches, therapist, etc.)
 - e. Other (participant can write in their answer if he/she wants)
18. What are the barriers to treatment for female adolescents at your agency?
- a. Scheduling barriers
 - b. Client resistance
 - c. Parent disagreement
 - d. Inconsistent messages from authority figures (parents, coaches, therapist, etc.)
 - e. Other (participant can write in their answer if he/she wants)
- Demographic Questions
19. What is your job title and licensures?
20. How many years have you worked in the field of eating disorder treatment?
21. How many years of experience have you had working with male and female adolescents suffering from an eating disorder?

Appendix B – Correspondence E-mail

My name is Cameron Green and I am currently in the graduate social work program at the University of St. Thomas/St. Catherine School of Social Work. As a part of my year long research project, I am conducting a short survey for practitioners to fill out. The purpose of this study is to investigate the similarities and differences in treatment approaches between male and female adolescents with eating disorders. Originally I planned on conducting interviews with local therapists in Minnesota. After scheduling and time constraints, I am changing the nature of my study from qualitative to quantitative. The only concern is my inability to send out my survey to more participants at a wider range. I am sending this e-mail to ask if there is a possible list serv with practitioners who work with adolescents that I could use to send an e-mail explaining the basics of the study and a link to an online survey that would take no more than 15 minutes. This would allow me to send a link to my survey out to a wide range of participants in order to complete my study.

Appendix C – Recruitment E-mail

Explanation of research:

You are invited to participate in a research study of how the treatment approach for adolescents with eating disorders differs between genders. Requirements are that you are a therapist that works with individuals with eating disorders with English reading proficiency to participate in this study.

Background Information:

The purpose of this study is to investigate the similarities and differences in treatment approaches between males and females with eating disorders.

The study is being conducted by: Cameron Green under supervision of Valandra, MSW, MBA, PH.D. from the University of St. Thomas Social Work Program.

Procedures:

If you agree to participate in this study click on the link and you will be taken to Qualtrics, an electronic survey program, to complete the demographics and the anonymous survey. You will be able to complete the survey in less than 20 minutes.

Confidentiality:

I will assure confidentiality/anonymity of participants. No names will be asked for in the survey. The research study will be published in the University of St. Thomas Library. In the research study I publish, I will not include information that will make it possible to identify you in any way. I will follow confidentiality guidelines by ensuring all data is permanently destroyed after analyzed.

Voluntary Nature of the Study:

Your participation in the study is voluntary and you are free to withdraw at any time during the process of completing the surveys

Risks and Benefits of being in the Study:

No inherent risks associated with participation in this study have been identified. The benefit result of this study will contribute to better understanding the treatment approaches for both male and female adolescents with eating disorders.

Contacts and Questions:

The researcher conducting this study is Cameron Green. He can be reached by email at gree8456@stthomas.edu

The link to the survey is below:

http://stthomassocialwork.qualtrics.com/SE/?SID=SV_eywKYkdUxYqqGN

Thanks for your participation.

Cameron Green