

Eating Disorders are Still Considered to be a Female Psychopathology?

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Eating disorders (ED) are usually considered a feminine pathology (Darcy & Lin, 2012; Striegel-Moore & Bulik, 2007), where the prevalence of male cases is considerably lower (Hoek, 2006). However, in many cases, men with ED go undetected because their problem is unknown and assessment is not always properly performed (Strother, Lemberg, Stanford, & Turberville, 2012). Contrary to the drive for thinness observed in women with ED (Striegel-Moore & Bulik, 2007), some men have concerns and receive social pressures oriented to increasing their physical size and muscle development (Baghurst et al., 2006; Pope et al., 1997). However, traditional assessment tools are not designed to evaluate the male body dissatisfaction and muscle-oriented eating behaviors (Darcy & Lin, 2012).

In this sense, previously Silberstein, Striegel-Moore, Timko, and Rodin (1988) found that women presented significantly higher scores than men in the Eating Attitudes Test-26 (EAT-26) (Garner, Olmsted, Bohr, & Garfinkel, 1982). Similarly, when using the Eating Disorders Examination (EDE) (Cooper & Fairburn, 1987) in men with anorexia nervosa (AN), they showed lower scores than women on the figure and weight concern subscales, and on the total score (Darcy et al., 2012). Likewise, in the Eating Disorder Inventory (EDI) (Garner, Olmsted, & Polivy, 1983) men tend to present lower scores than women, and it is considered to present a modest sensitivity to identify men with ED (Geist et al., 1999; Kjelsås, et al., 2003). All together, the EAT-26, the EDE and the EDI are considered among the most appropriate instruments to assess ED in women (Kashubeck-West, Mintz, & Saunders, 2001). However, they evaluate dimensions that do not accurately represent problems in male disordered eating (Darcy et al., 2012; Darcy & Lin, 2012).

According to Parent (2013), the drive for muscularity represents the pursuit of the male body ideal that in its extreme forms may involve Muscle dysmorphia (MD). The MD is a psychiatric condition that has gained notoriety since its first description in the late 90s. It was originally considered as the male analog version of AN, identified as Reverse Anorexia where the main body concern was related to a desire to increase the physical size (Pope, Katz, & Hudson, 1993), unlike the typical fear of gaining weight seen in women with AN. However, later it was conceptualized as a subtype of Body Dysmorphic Disorder (BDD) (Pope et al., 1997).

MD is characterized by chronic concern with muscularity and the desire to increase body size, which generates significant clinical distress and functional impairment. Among the compensation strategies that people with MD develop, avoidant behaviors and reassurance seeking are observed. Also, men with MD tend to stick to specific dieting plans and compulsive exercise (Pope et al., 1997). Unlike other people with BDD, subjects with MD are most likely to lift weights and practice physical exercise compulsively, attempt suicide, misuse substances (food supplements, instead of laxatives or diuretics), and develop disordered eating patterns, which results in a poorer quality of life (Pope et al., 2005). Although according

to the DSM 5 (APA, 2013) it is currently considered as a subtype of BDD within the obsessive-compulsive and related disorders, clinical psychologists tend to associate the symptoms observed in MD within the ED spectrum (Murray & Touyz, 2013). Similarly, there is increasing scientific evidence linking the drive for muscularity and MD, with ED (Compte et al., 2015; Murray et al., 2012).

According to a review by Cafri and Thompson (2004), the Drive for Muscularity Scale (DMS) (McCreary & Sasse, 2000) stands out as one of the most appropriate measures to evaluate behaviors and attitudes associated with male body dissatisfaction. For example, the DMS includes items related to dysfunctional physical practice (e.g., "I think that my weight training schedule interferes with other aspects of my life."), and altered eating behavior (e.g., "I try to consume as many calories as I can in a day"). Despite being widely used and validated in different populations (Campana et al., 2013; Compte et al., 2015; Escoto et al., 2013; McPherson et al., 2010), Tylka, Bergeron, and Schwartz (2005) consider that the DMS does not take into account issues of body image unrelated to muscularity. Consequently, the authors develop the Male Body Attitudes Scale (MBAS) (Tylka et al., 2005), which in addition to assessing the desire to become more muscular also includes subscales with items related to concerns about body fat (e.g., "Has eating sweets, cakes, or other high calorie food made you feel fat or weak?") and height (e.g., "I wish I were taller."). Although the MBAS has appropriate psychometric properties and has also been validated in different populations, the validity of the height subscale has been questioned since it comprises of only two items (Bellshill & Vanderwal, 2009). In this sense, the Spanish validation excludes the height subscale and retains the subscales evaluating concerns about muscle and body fat (Sepulveda, Anastasiadou, Pellegrini et al., 2014). Although there are currently more than 30 instruments that are appropriate to assess male body dissatisfaction (Parks & Sepulveda, 2013), the DMS and the MBAS are considered within the most accurate measures to assess ED and MD among men (Greenberg & Schoen, 2008).

A recent study conducted in Buenos Aires, (Compte, Sepulveda, & Torrente, 2015) has estimated the prevalence of eating disorders and MD in a representative sample of male college students. It was observed that by using assessment tools originally developed in female population, the participants presented lower prevalence rates of ED than women, compared to data from previous studies. However, by using instruments developed and validated to assess male body dissatisfaction, participants showed similar prevalence rates to those previously observed in women with ED. According to the aforementioned, the use of instruments developed and validated in female populations tends to underestimate male body image concerns and disordered eating. Therefore, men with ED go unnoticed in clinical practice and fail to receive proper treatment (Strother et al., 2012).

Nowadays, ED represents a challenge to public health. Not only for their psychiatric comorbidity, functional impairment, and high prevalence of suicide attempts (Hudson et al., 2007; Preti et al., 2011), but also because they affect the quality of life of those who

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suffer from an ED and of their caregivers (Anastasiadou et al., 2014; Carta et al., 2014). Additionally, it has been argued that the low rates of people with an ED that receive appropriate professional help (Hudson et al. 2007) may be due to deficiencies in the identification of primary care settings (Carta et al., 2014). In addition to that, if we consider that the assessment of ED tends to ignore the male body image concerns and muscle-oriented behaviors, the rates of men with ED that do not receive adequate help can be even greater.

If we consider that early detection of ED is associated with better treatment outcomes (van Son, van Hoek van Furth, Donker, & Hoek, 2010), and a decrease in suicide rates (Preti et al., 2011), it is of great importance that scientific research and clinical training consider specific gender aspects in the assessment and treatment of ED and body dissatisfaction in men.

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