

METHODOLOGICAL ARTICLE

Navigating Treatment: A Framework Analysis of Perspectives of Male Adolescents With Disordered Eating in Clinical Settings

Shauna E. Byrne¹, Liam J. Casey², and John McAloon¹¹ Family Child Behaviour Clinic, Discipline of Clinical Psychology,
Graduate School of Health, University of Technology Sydney² Discipline of Clinical Psychology, Graduate School of Health, University of Technology Sydney

Despite an increase in the number of male adolescents experiencing disordered eating, the number entering treatment remains low. Accordingly, significant gaps continue to exist in our understanding of male adolescents' experience within treatment. This may result from limitations in the amount of research undertaken in the area; however, it may also result from the continued influence of established theoretical models of disordered eating. While models such as Fairburn et al.'s (2003) transdiagnostic model of eating disorders have been foundational in the classification, assessment, and treatment of disordered eating, they may also have inadvertently skewed perceptions of adolescent eating disorders. Evidence suggests that the traditional focus on a "thin" body ideal may apply more to females than males. By contrast, male adolescents may pursue a larger body with increased emphasis on muscularity and, therefore, weight gain. This study aimed to investigate the experiences of 10 male adolescents aged between 13 and 19 years who were undergoing treatment for eating disorders. The study explored participants' diagnosis and treatment experiences using a demographic survey and semistructured interview. Framework analysis revealed five eating disorder themes and 11 subthemes. These may assist our understanding of male adolescents' experience of eating disorders, their identification, diagnosis, and treatment. The findings highlight the influence of current theoretical models with respect to diagnostic labeling and individualized treatment approaches. They underscore the importance of the client–psychologist connection and the stigma and isolation that male adolescents may experience prior to and during treatment for eating disorders.

Keywords: male, adolescent, eating disorder, qualitative, clinical treatment

Supplemental materials: <https://doi.org/10.1037/qap0000299.supp>

Despite the growing number of male adolescents experiencing disordered eating (DE), the rates of male adolescents entering treatment for eating-related concerns remains alarmingly low (Ganson et al., 2021; Limbers et al., 2018).

As such, much remains unknown about the experiences of male adolescents once they attempt to seek treatment for an eating disorder (ED) within a clinical setting (Räsänen & Hunt, 2014).

Shauna E. Byrne  <https://orcid.org/0000-0002-1952-2090>

Liam J. Casey  <https://orcid.org/0000-0003-2299-8062>
John McAloon  <https://orcid.org/0000-0001-8896-2578>

Open Access funding provided by University of Technology Sydney: This work is licensed under a Creative Commons Attribution 4.0 International License (CC BY 4.0; [https://](https://creativecommons.org/licenses/by/4.0)

creativecommons.org/licenses/by/4.0). This license permits copying and redistributing the work in any medium or format, as well as adapting the material for any purpose, even commercially.

Correspondence concerning this article should be addressed to John McAloon, Family Child Behaviour Clinic, Discipline of Clinical Psychology, Graduate School of Health, University of Technology Sydney, 67 Thomas Street, Ultimo, NSW 2007, Australia. Email: john.mcaloon@uts.edu.au

Prevalence

Rates of prevalence of DE and EDs in male adolescents are difficult to determine and likely underestimate the proportion of those affected by DE (Murray et al., 2018). While the often-quoted gender ratio of 9:1 for ED diagnosis between females and males holds true for adults presenting for treatment, epidemiological studies provide estimates of prevalence that are closer to 4:1 (American Psychiatric Association [APA], 1994; Madden et al., 2009). In a study of 2,495 Australian male adolescents, 12.8% met criteria for various ED diagnoses, including other specified feeding and eating disorder (8.5%), night eating syndrome (4.9%), bulimia nervosa (1.8%), purging disorder (1.6%), unspecified feeding and eating disorder (1.3%), and atypical anorexia nervosa (1.2%; Mitchison et al., 2020). Despite this, male adolescents are less likely to present for treatment for an ED compared to female adolescents and may therefore be left underdiagnosed and undertreated (Ganson et al., 2021; Strother et al., 2012).

Thus, in accordance with APA guidelines (APA, 2020, p. 135) this qualitative study employs the term “male adolescent” to specify focus on the unique experiences of young individuals who identify as male and are in the developmental stage of adolescence in the context of ED treatment. Additionally, the decision to differentiate between “male” and “female” in this study is grounded in the recognition of nuanced gender differences. We acknowledge the distinction between “male” and “female” as descriptors for biological sex, while “man” and “woman” encompass broader considerations of gender identity. We utilize the terms “males” and “females” in this research when referring to groups that include individuals with a broad age range, as outlined in the APA guidelines (APA, 2020, p. 135). This approach that recognizes that male adolescents’ experiences in ED treatment may differ from that of females adheres to APA guidelines to promote transparency and precision, ensuring accurate representation of the distinct aspects of the male adolescent experience.

Lack of Males Adolescents Presenting for Treatment

Less than 1 in 10 male adolescents experiencing DE seek treatment and, if they do, it may occur late in their ED trajectory, potentially leading to more severe medical complications (Forrest et al.,

2017; Limbers et al., 2018). Additionally, male adolescents’ presentation to clinical settings was often found to occur for treatment of comorbid conditions, such as anxiety and depression, rather than for an ED (Burton et al., 2022). This is problematic as the effectiveness of therapeutic interventions decrease and the risk of serious health consequences increase as time in treatment increases (Coffino et al., 2019). Male adolescents’ late entry into treatment may be due to stigma about seeking mental health treatment, particularly where male gender roles traditionally imply self-reliance, independence, and resilience (Griffiths et al., 2015; Grillot & Keel, 2018). Additionally, given the historical assumption that EDs primarily affect females, male adolescents may be less likely to recognize their own weight- and appearance-related behaviors as DE (Burton et al., 2022; Fatt et al., 2020). This is concerning as males who were reticent to receive care for an ED and were unaware of their ED symptoms were more likely than females to have an untreated ED (Fatt et al., 2020; Griffiths et al., 2015). Outcomes such as these may, in part, have resulted from the paucity of research into characteristics of presentation, screening, and treatment for male adolescents with DE (Murray et al., 2017).

Male Adolescent Representation in ED Research

Throughout the 20th century, EDs have largely been characterized by female phenotypic characteristics. For example, the diagnostic criteria of amenorrhea, included in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; APA, 1994), does not apply to males (Lavender et al., 2017). As such, many of our current assumptions regarding EDs in males may originate from research appropriately developed with female participants yet generalized to males (Darcy, 2011; Ganson et al., 2021). A significant proportion of existing ED research has focused on adult males and females and employed quantitative research methods to collect data on their treatment (Thapliyal et al., 2020). Several recent studies have addressed this issue by exploring the treatment experiences of adult males; however, there is limited recent qualitative research about male adolescents’ experiences of ED treatment (Kinnaird et al., 2019; Thapliyal et al., 2020). Thus, we identified only

one qualitative study conducted by [Mitrofan et al. \(2019\)](#), which investigated the experiences of young adults undergoing ED treatment. This study did not, however, examine male-specific eating concerns and instead targeted male and female adolescents and young adults aged 16–25 years. Examining male adolescent EDs through the lens of the female gender risks ignoring unique characteristics of the male experience and may, therefore, have significant implications for the development of treatments and their effectiveness ([Darcy, 2011](#)). Similarly, generalizing assumptions developed within adult research and treatment literature may be inappropriate due to differences in prevalence, characterization, and trajectories of eating difficulties across early to late adolescence ([Byrne et al., 2023](#); [Darcy, 2011](#)).

Conceptual Models of Male Adolescent ED Risk Factors

The tendency to consider male adolescent EDs from the perspective of ED characteristics of females may have also been perpetuated by the influence of established theoretical models ([Byrne et al., 2023](#)). For example, according to [Fairburn et al.'s \(2003\)](#) transdiagnostic model of eating disorders, it is the overvaluation of a “thin” body weight and shape, in particular, that underpins many of our current treatment approaches, assessment measures, and diagnostic criteria ([Lavender et al., 2017](#)). However, contrary to the model, early studies of male body dissatisfaction have revealed that males may overvalue a larger body and report a desire to gain muscle instead of lose fat ([Murray et al., 2017](#)). According to the sociocultural theory ([Thompson et al., 1999](#)), this dissatisfaction results from unrealistic standards that are set in Western society that a majority of adolescents fail to meet. Appearance standards conveyed in Western social media that traditionally concentrate on female thinness now focus increasingly on muscularity and leanness, two essential components of appearance ideals for both males and females ([Rodgers et al., 2018, 2020](#)).

For males, the characteristics of muscularity and low body fat may serve as dual standards against which ideal male appearance is evaluated ([Murray et al., 2017](#)). Thus, the internalization of the muscular ideal by male adolescents may result in the engagement of a unique variety of DE attitudes and behaviors to achieve this standard

([Lavender et al., 2017](#)). While females may more commonly engage in eating restriction and purging to achieve the thin ideal, males more commonly engage in behaviors directed at achieving leanness and muscularity, including exercising and dieting to enhance muscle gain ([Lavender et al., 2017](#)). Nevertheless, there is a notable lack of established diagnostic criteria for EDs that specifically address DE centered around a focus on muscularity rather than thinness ([Murray et al., 2016](#)).

Assessment of Male Adolescents With EDs

Male adolescent patients are diagnosed with EDs by medical professionals less frequently than adolescent females ([Ganson et al., 2021](#); [Lindvall Dahlgren et al., 2017](#)). This may reflect the limitations of prominent ED assessment measures. For instance, the Eating Disorder Examination Questionnaire ([Fairburn & Beglin, 2008](#)) and the Eating Disorders Inventory ([Garner, 2004](#)) may be limited in their capacity to capture male-specific eating related characteristics. Despite recent research indicating the appropriateness of such ED measures with males ([Carey et al., 2019](#); [Smith et al., 2017](#)), some evidence suggests that limitations may result from their continued use with female DE and ED populations ([Limbers et al., 2018](#); [Smith et al., 2017](#)). For example, male adolescents with DE may pursue an increase in muscularity rather than a decrease in body weight. This, together with an overemphasis on exercise, may limit their ability to satisfy the initial body mass index criterion prescribed for ED diagnoses ([Lindvall Dahlgren et al., 2017](#); [Nagata et al., 2019](#)). Thus, the accurate diagnosis of male adolescents may not be precluded; however, it may follow later in a presentation to treatment than is the case for females and may result in more severe ED symptomatology than is the case for females ([Thapliyal et al., 2018](#)).

Identification and Diagnosis of Male Adolescents With EDs

The timely assessment and treatment of DE and EDs is essential for optimal treatment outcomes; however, limitations in research can have significant implications for the training of medical and health professionals ([Ganson et al., 2021](#)). Research shows that many medical practitioners are unprepared to identify and treat EDs, with 70% receiving fewer than 5 hr of training in child and

adolescent EDs (Ganson et al., 2021; Girz et al., 2014). As such, access to ED treatment may also be more difficult for male adolescents due to specialists' limited knowledge about their symptoms and the concerns that underlie their presentations (Robinson et al., 2013). An accurate appraisal of presenting symptoms and the provision of pertinent and suitable information on EDs have both been demonstrated to proceed as a function of the sex of the patient (Räsänen & Hunt, 2014; Robinson et al., 2013). In addition, more than 92% of doctors indicated that they believed they missed an ED diagnosis in male patients, and 68% reported that they did not do additional screening for an ED because it was not the presenting issue (Linville et al., 2012).

Indeed, more than half of the male adolescent ED patients' first outpatient visits have been reported to require urgent hospitalization, due to inadequate assessment and identification of ED symptoms (Vo et al., 2016). These findings are concerning as medical practitioners are commonly the first point of contact for individuals with EDs, and they play an essential role in identifying, assessing, and medically treating EDs (Ganson et al., 2021). Yet, doctors report a lack of clarity about the assessment and treatment of male eating concerns, potentially leading to delays in treatment and exacerbating health complications (Linville et al., 2010). Consequently, male adolescents may encounter challenges in obtaining an accurate ED diagnosis even when seeking treatment, as research suggests that they are often diagnosed with other mental health conditions, such as affective and anxiety disorders, rather than EDs (Burton et al., 2022).

ED Treatment Outcomes for Male Adolescents

When detected and managed early by trained and knowledgeable health professionals, approximately 72% of individuals with EDs achieve full recovery and a good quality of life (Butterfly Foundation, 2017). The most influential aspects of male adolescence treatment experience have been identified as the therapist's personality, the quality of the therapeutic interactions they fostered, and the trust and confidence in them (Dearden & Mulgrew, 2013; Thapliyal et al., 2017). Young adult males diagnosed with EDs have also reported that attending treatment groups

comprised solely of males decreased feelings of isolation and increased their perception of safety about discussing their food and body image concerns (Robinson et al., 2013; Thapliyal et al., 2018). As such, health practitioners supporting and treating male adolescents with EDs may extend existing treatment parameters to challenge "masculine" ideals of strength, power, and control that coincide with male eating difficulties (Griffiths et al., 2015; Thapliyal et al., 2018).

Aims and Objectives

Existing conceptual models, such as the transdiagnostic model of EDs (Fairburn et al., 2003), emphasize cognitive and emotional factors associated with female EDs. By contrast, the sociocultural theory (Thompson et al., 1999) highlights societal factors hypothesized to influence body image, but their applicability to the experiences of male adolescents with EDs is underexplored. Further qualitative research may inform existing theoretical frameworks as well as processes of identification, diagnosis, and treatment of male adolescents with EDs (Räsänen & Hunt, 2014; Thapliyal et al., 2020). Therefore, the aim of this study was to explore the relation between cognitive, emotional, and sociocultural characteristics of male adolescents' experience of EDs within the context of psychological treatment for EDs.

Method

Study Design

This research study used semistructured interviews to gain a comprehensive understanding of the male adolescents' thoughts, feelings, and beliefs about their experiences in seeking treatment for DE and EDs (Creswell & Clark, 2017; DeJonckheere & Vaughn, 2019). Given the personal and sensitive nature of some of the issues that adolescents may face with their eating behaviors, and in treatment for such, it was felt that individual interviews would provide a safe and open environment for participants to express themselves.

Participants

Participants were male adolescents recruited from two private psychology practices in New

South Wales, Australia. Agreement to participate in the demographic survey and semistructured interview was gained from $N = 10$ male adolescents ($M_{\text{age}} = 16.00$, $SD = 2.79$). Participants who met inclusion criteria were included in the research: Criteria were that participants identified as male, were aged 11–19 years, had not previously been diagnosed with a neurodevelopmental disorder, and had not previously been the subject of a child protection concern or placed in and out of home care or detention. Female participants ($n = 9$) were excluded from the study, and despite providing initial consent, three male adolescent participants declined to participate in the semistructured interview. [Figure 1](#) presents details about the participant selection process. Eligible participants described their ethnicity as Asian ($n = 1$), Australian ($n = 4$), European ($n = 1$), Greek ($n = 1$), Indian ($n = 1$), Irish ($n = 1$), and Russian ($n = 1$). Demographic details of the participants and pseudonyms to which their personal quotes are attributed are presented in [Table 1](#). Treatment and diagnostic data for those included in the study are presented in [Table 2](#).

Procedure

Recruitment and Data Collection

Ethical approval for the study was granted by the University of Technology Sydney Human Research Ethics Committee (approval number: ETH21-5909). Male adolescents were invited to

participate in the research following discussion with the first author. This discussion was undertaken with the treating psychologist present to ensure no prior relationships between the first author and participants existed. Informed consent to participate in the research was gained from participants, and if they were under the age of 18 years ($n = 7$), parental informed consent was also gained. Purposive sampling was employed to identify participants undergoing ED treatment across a diverse range of age, ED types, and comorbid diagnostic characteristics. An evolving matrix of participant characteristics guided the sampling process, with recruitment continuing until a comprehensive range of characteristics was achieved.

Participants were provided with a link to the online survey that was hosted on Qualtrics. Completion of that survey took approximately 10 min. Following completion of the survey, participants were able to opt-in to a one-to-one semistructured interview with the first author by providing their contact details. Interviews were conducted in person ($n = 9$) or via the online teleconference platform Zoom ($n = 1$; [Zoom Video Communications, 2016](#)), at an agreed time. All interviews were conducted by the first author, a clinical psychologist experienced in clinical work with individuals with EDs. Interviews were conducted between October 2022 and February 2023 and varied between 15 and 27 min in length ($M = 21$ min, $SD = 4.13$ min).

Figure 1
Participant Selection Flowchart

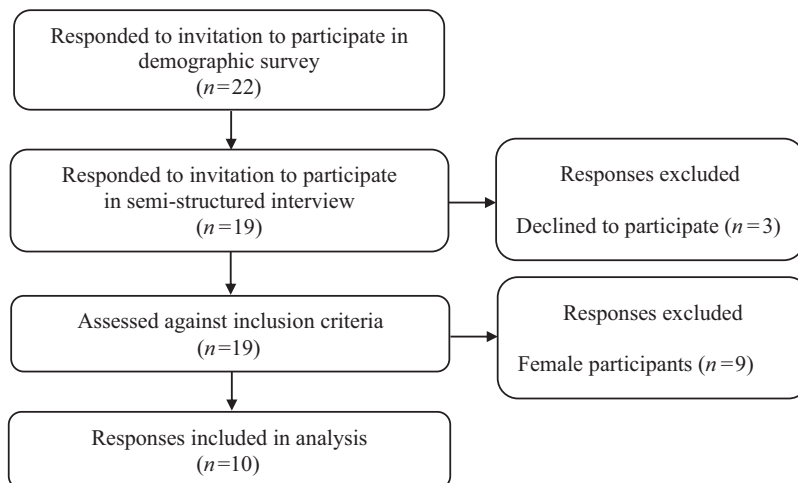


Table 1
Demographic Information and Pseudonyms

Interview	Pseudonym	Age	Gender	Nationality
1	Mark	18	Male	Australian
6	Lucas	19	Male	Australian
7	Ben	19	Male	Australian
8	Sean	16	Male	Irish
9	Alex	17	Male	Russian
10	Kieran	19	Male	Greek
11	Ryan	14	Male	Australian
12	Michael	12	Male	Asian
13	Peter	13	Male	Indian
16	Chris	13	Male	European

Materials

Demographic Information Questionnaire

Participants were first asked to provide a range of demographic information including age and ethnicity.

Eating Disorder Treatment and Diagnosis Information Questionnaire

This survey was developed for the present study to gain insight about the experiences of male adolescents undergoing psychological intervention for an ED. The survey contained 16 items in free-response and multiple-choice formats and included the age of ED commencement and help seeking, the health professionals they had consulted, the number of treatment sessions they had completed, their ED diagnoses, the number of sessions it took before their ED was diagnosed, their comorbid mental health diagnoses, the treatment plans and treatment modalities utilized, and their report of the impact of their ED on their life.

Semistructured Interview

The semistructured interview schedule was developed by the first author following discussion between the authors. To ensure that questions were sensitive and relevant to the participants' treatment experience, insights from the online survey, such as characteristics of the participants' treatment experience, were used to identify key areas of interest and to shape the interview questions. Individual interview questions were further refined based on a review of current research and treatment evidence and clinical experience. This approach was designed

to elicit nuanced insights from the participants and allow for a comprehensive understanding of their perspectives and experiences beyond those that may be gained using traditional multiple-choice questionnaires.

The interview consisted of 10 open-ended questions that sought participant responses about specific ED behaviors, their comorbid mental health concerns, their rapport with their therapist, their knowledge about the treatment they received, the limitations and benefits they experienced with treatment, and participant suggestions for improvements to ongoing ED treatment and psychological support. Participant responses to the interview schedule enhanced the quality of the data collected, and on completion of the interview, participants were asked to add anything they believed to be important or meaningful that had not yet been discussed.

Reflexivity

To engage in reflexivity, the first author examined her own biases and assumptions as a White, female, clinical psychologist with experience working with EDs. As such, she was conscious of bracketing her own conceptual lens and explicit and implicit assumptions, preconceptions and values, to ensure that her prior knowledge of the practices and participants did not bias her results (Lincoln et al., 1985). To do this, she kept a reflexive journal, detailing her thoughts after each interview, while reading transcripts, and during the data analysis process (Lincoln & Guba, 1982; Vicary et al., 2017). She engaged in debriefing sessions with fellow research team members to enrich the analysis and bolster its credibility (Creswell & Miller, 2000; Lincoln & Guba, 1985). This process involved integrating various team perspectives and insights, which in turn helped in scrutinizing and honing initial ideas, resulting in a deeper comprehension of the data (Spillett, 2003). Additionally, peer validation of the first author's initial interpretations assisted in mitigating potential biases, contributing to a more robust analysis and ensuring that the final themes accurately reflected the experiences of the participants (Lietz & Zayas, 2010; Lincoln & Guba, 1985).

Data Management and Analysis

Quantitative demographic data were entered into SPSS Version 28 (IBM Corp, 2020) to

Table 2
Eating Disorder Treatment and Diagnosis Characteristics of Male Adolescents

ED treatment and diagnosis characteristic	Male (n = 10) n (%)
Age DE Began	
5–8 years	1 (10.0%)
9–12 years	8 (80.0%)
17–19 years	1 (10.0%)
Age first sought professional help for DE	
9–12 years	1 (10.0%)
13–16 years	6 (60.0%)
17–19 years	3 (30.0%)
First health professional seen	
Counsellor	2 (20.0%)
ED specialized psychologist	1 (10.0%)
GP	6 (60.0%)
Psychologist	1 (10.0%)
Overall number of sessions with a psychologist	
Three sessions	2 (20.0%)
Five sessions	1 (10.0%)
More than six sessions	2 (20.0%)
More than 10 sessions	2 (20.0%)
More than 20 sessions	3 (30.0%)
ED diagnosis	
Anorexia nervosa	3 (30.0%)
ARFID	0
Atypical anorexia nervosa	3 (30.0%)
Binge eating disorder	3 (30.0%)
Bulimia nervosa	3 (30.0%)
UFED	1 (10.0%)
Number of psychology sessions before ED diagnosed	
0 sessions	1 (10.0%)
One session	3 (30.0%)
Two sessions	1 (10.0%)
Three sessions	3 (30.0%)
Four sessions	2 (20.0%)
More than 10 sessions	0
Comorbid mental health diagnoses	
ADHD	5 (50.0%)
Anxiety	6 (60.0%)
ASD	0
Depression	1 (10.0%)
Medicare plan provided	
Mental health care plan	8 (80.0%)
Eating disorder plan	7 (70.0%)
Treatment methods	
CBT-E	2 (20.0%)
FBT	6 (60.0%)
Hospitalization needed	1 (10.0%)
Inpatient hospital	1 (10.0%)
Outpatient hospital	0
Weight regain needed	7 (70.0%)
Unsure of treatment method	3 (30.0%)
Life areas impacted by ED	
Education	5 (50.0%)
Friendships	9 (90.0%)
Hobbies	8 (80.0%)

(table continues)

Table 2 (continued)

ED treatment and diagnosis characteristic	Male (n = 10) n (%)
Job	1 (10.0%)
Mental health	9 (90.0%)
Parent relationships	9 (90.0%)
Physical health	8 (80.0%)
Sibling relationships	5 (50.0%)

Note. DE = disordered eating; ED = eating disorder; GP = general practitioner; ARFID = avoidant restrictive food intake disorder; UFED = unspecific feeding and eating disorder; ADHD = attention deficit hyperactivity disorder; ASD = autism spectrum disorder; CBT-E = cognitive behavior therapy for eating disorders; FBT = family behavior therapy.

generate descriptive statistics. To analyze the qualitative data, interview recordings were transcribed by an independent professional transcription service and were then checked against the voice recordings for accuracy by the first author. The final transcripts were then uploaded into Nvivo12 (Lumivero, 2020). The interview data were then analyzed using five key activities of framework analysis (FA) outlined by Ritchie and Spencer (1994). FA belongs to a family of qualitative methods known as thematic analysis (Gale et al., 2013) and shares many features with Braun and Clarke’s (2006) popular reflexive approach to thematic analysis (e.g., the ability to code data inductively or deductively: (Braun & Clarke, 2021; Gale et al., 2013)). The FA method was chosen to analyze the qualitative data as it provided flexibility and freedom in the analysis process because it is not constrained by a specific epistemological position (Gale et al., 2013). This approach is popular among researchers as it enables them to tailor their approach to fit the aims of their research (King & Brooks, 2018; Ritchie & Spencer, 1994). Additionally, FA is appropriate for exploring contextual research questions that relate to the nature of the individuals’ experiences, making it a good fit for the present study (King & Brooks, 2018; Ritchie & Spencer, 1994). The five FA activities were carried out in the present study in the following way. Initially, the first author read and reread the interview transcripts to immerse herself in the overall content of the data, while taking notes on her initial impressions using the Nvivo12 (Lumivero, 2020) memo feature (familiarization). Next, the first author and a student researcher used the interview questions

as an a priori guide to develop a thematic framework by identifying and assigning initial open codes to recurring themes and concepts in the raw data in each participant transcript (developing an analytical framework). The first author then reread the data and systematically indexed the data by assigning codes to specific sentences across the entire data set. These indices related to the identified themes and subthemes (indexing). The indexed data was then sorted into charts in Excel, with themes and subthemes charted in columns and participant responses charted in rows. This process allowed the researcher to compare different themes across participants and identify patterns in the data (charting). Finally, identified patterns in the data facilitated a broader understanding of it and allowed the researchers to draw conclusions about commonalities and differences across participant responses and identified themes (mapping and interpretation).

Rigor and Trustworthiness

The study's trustworthiness was established in accordance with standards outlined by Lincoln et al. (1985), through an evaluation of its credibility, transferability, dependability, and confirmability. Regarding credibility, researcher triangulation was implemented, whereby all transcripts were examined by the first author, followed by examination of a subset of transcripts by a student researcher, and findings were repetitively discussed between the coauthors (Onwuegbuzie & Leech, 2007). Participant quotes from original interviews were also included in results to accurately articulate the participants' experiences and reinforce credibility (Graneheim & Lundman, 2004). All participant quotes were verbatim, but where abbreviation occurred, it was identified by an ellipsis and substantive meaning was not altered. Additionally, in the FA of the qualitative data, trust was established between the first author and participants through engagement in the data collection process, and the credibility of the analysis was enhanced through the first author's prolonged engagement with the data (Bitsch, 2005; Krefling, 1991).

In order to enhance the applicability of the study's findings to similar contexts, transferability was established through a detailed description of the study's context, participants, recruitment process, and interview procedure (Li, 2004). To ensure the dependability of the study, the study procedure has been described in detail to provide

a retraceable path from the beginning of the study to the development and documenting of the findings (Bowen, 2009; Li, 2004). Records of the raw data, transcripts, and a reflexive journal made through memos in NVivo12 also enabled the first author to systematize, convey and cross-reference data to establish confirmability and dependability (Koch, 1994; Vicary et al., 2017). Finally, a thorough justification of the study's choices regarding purpose, participants, methodology, analysis, and conclusions was incorporated in reporting to establish confirmability of the study findings (Bowen, 2009; Koch, 1994).

Results

Five main themes were identified following thematic analysis of the interviews. These were (a) identification of the ED, (b) diagnosis of the ED, (c) benefits of ED treatment, (d) issues with ED treatment, and (e) future treatment needs. Based on the views of the participants, these themes are further divided into 11 subthemes. Illustrative quotes for each theme and subtheme are presented in Table 3.

Theme 1: Identification of the ED

The first theme explored the male adolescents' experiences of ED symptoms and the processes that they underwent to receive professional treatment for such. These experiences are explored in subthemes related to the participants' engagement in ED thoughts or behaviors and their awareness of the disordered nature of these behaviors. Additionally, their experiences of seeking professional help for their ED concerns and receiving ED diagnoses, were explored in context of their presentation to health professionals for support with comorbid mental health concerns.

Awareness of ED Symptoms

In the first subtheme, awareness of ED symptoms, a majority of participants discussed ED symptoms, including reducing food intake, binge eating, purging behavior, and laxative use. They also discussed their lack of understanding of their symptoms and ways they dealt with this prior to receiving professional assistance. For example: "I didn't think I was bad enough" (Ryan). Chris also shared that he was noticing abnormal behavior regarding eating; however, he

Table 3
Illustrative Quotes Related to Themes and Subthemes

Theme	Subtheme	Illustrative quote
1. Identification of the ED	1.1: Awareness of ED symptoms	Lucas: There was a few times where I would always just give all my food to everyone else so then I could pretend, like I ate, because I ate breakfast, starved myself throughout the entire day. ... I gave out, chucked out whatever I could ... so that there was perception that I ate it.
	1.2: Prioritization of comorbid mental health concerns	Sean: I honestly felt like I had depression way before anything was wrong with my eating. ... I thought like exercising would actually make me feel better about myself.
2. Diagnosis of ED	2.1: Resistance to ED diagnoses	Ben: I think, maybe, subconsciously, I was aware of it but didn't want to accept the diagnosis.
	2.2: Misunderstanding of male-specific issues	Kieran: I think the sensitivity and understanding is definitely important. Like I've been through a couple of psychologists. ... It's been a bit too concrete and they haven't shown enough compassion. ... I didn't feel understood or heard.
3. Benefits of ED treatment	3.1: Individualized approach	Alex: We can talk about obviously things like vomiting and all of that kind of stuff but then we can also talk about just my normal kind of stuff ... my anxiety ... and um ways to help that as well ... so I don't have to feel like pressure just to talk about the eating ... we kind of leave it open and then go from there each session.
	3.2: Rapport with psychologist	Michael: Yeah they're really good, we do fun activities together as well ... they help me understand different food things so we do some work in the kitchen and work on my eating and my tastes as well trying to get used to different tastes and foods
	3.3: Helpful treatment components	Peter: It was good to have my parents there because they helped me to actually stop vomiting at times when I really wanted to.
4. Issues with ED treatment	4.1: Disconnection with psychologist	Mark: I sort of didn't really love going because I felt like I was sort of like getting examined by them. ... I genuinely didn't enjoy coming in.
	4.2: Difficulty adhering to treatment components	Ben: I'm like, "I don't really like CBT." But I was willing to give it a go, but it felt a bit like gaslighting myself.
5. Future needs	5.1: Further treatment required	Alex: Oh yeah like I will still need help with my anxiety probably ... and I haven't fully like stopped vomiting just yet so still need to work on that ... probably some other stuff like, you know, around my weight and my body or things like that and building up my confidence around my friends as well that would probably be important too ... so yeah I still need to do work on that stuff.
	5.2: Tailored treatment for males	Chris: I think it would be good to have some kind of support group. ... Like I know they are out there but not at the clinic I was at ... because none of my friends could really understand why I just wouldn't eat. They would just ask triggering questions and stress me out so having some people who understood around would be good I think. ... I mean besides family, like other people that get it.

Note. ED = eating disorder; CBT = cognitive behavior therapy.

did not recognize these behaviors were a problem at first as he stated, “I was getting anxiety around counting calories so I could lose fat, I think that’s what the psychologist helped me to realize, it is actually a problem.”

During the discussion, various participants revealed that they employed several different methods to manage their eating habits and that they initially began to control their food-related behaviors on their own. Alex described it in the following way:

I’ve done some research on some of these websites to try to lose weight and one of them said to take laxatives I guess to make sure that I didn’t absorb the food that I was eating. So, I actually ended up buying those.

Tracking calories was another method cited by participants trying to gain control over their diet or to maintain or reduce weight. Kieran described it as:

Hyper-fixating on numbers and energy values, and that sort of thing. ... I was binging a lot, at first ... there was also purging behaviors, so I would chew and spit for food instead of swallowing it to restrict my calories. I would also eat, feel guilty, then exercise for over an hour.

It was also reported by some participants that they were concerned with maintaining exact measurements of food groups and calories to facilitate their exercise and muscle-building goals. For example, Chris shared that he had stopped eating out because he “couldn’t measure properly and count the calories fully.” Additionally, Sean expressed concern about missing workouts after eating as he stated, “I ended up just doing lots of workouts at home but that was a bit of an issue for me because I was worried about missing a workout too.”

Prioritization of Comorbid Mental Health Concerns

In addition, participants were asked if they had sought professional help for conditions other than EDs. A majority reported receiving support for anxiety and depression. During the discussion, it was reported that general practitioners (GPs) assisted participants in initially assessing other mental health concerns, wherein they also obtained a preliminary understanding of their ED behaviors and attitudes and were encouraged to see an independent psychologist. For instance, Kieran stated “I went to my GP when I was feeling low, and they screened me with questionnaires

and basically told me I have signs of bingeing and bulimia behaviors.”

Some of the participants who initially visited psychologists for anxiety or depression reported that they were also informed that they were experiencing an undiagnosed ED that was impacting their mental health, yet they were unable to identify that until they sought professional care. Mark expressed gaining a better understanding of his ED after seeing a psychologist as he stated “I sort of went to see a psychologist mainly because of depression ... but the depression was also a catalyst for the eating disorder ... food was a comfort thing.”

Participants in Theme 1 recounted their experiences of ED symptoms, initially unaware of the disorder, and resorted to self-implemented management strategies such as calorie tracking and purging behaviors. As they sought assistance from health professionals for co-occurring mental health issues like anxiety and depression, participants gradually acknowledged their ED concerns through engagement and information they received in ED treatment.

Theme 2: Diagnosis of ED

As the participants entered treatment, some described mixed responses to receiving an ED diagnosis. For some, the label of ED was perceived as feminine and inappropriate to their experience. Others considered that their behaviors were severe enough to be regarded as EDs. These experiences were explored in subthemes related to the participants’ resistance to the diagnostic labeling of EDs and feeling their specific concerns were not accurately captured in the assessment and treatment process.

Resistance to ED Diagnoses

Various participants in the study expressed dissatisfaction with the diagnostic labeling of their ED. They reported that they were aware that something was wrong but had difficulty accepting that they had an ED when their psychologist identified it. For example, Ben perceived it as stigmatizing and was consequently unhappy to have received an atypical anorexia diagnosis as he stated, “The diagnosis of like atypical anorexia. ... I think it’s a horrible way to name it ... and from the get-go it just felt layered in stigma to me.”

Similarly, Alex said that he felt an ED diagnosis was a female problem and found it difficult to

accept it was something he was experiencing as he stated, "I just found it confronting to have to go cool I have like an anorexia diagnosis or a bulimia diagnosis because that felt really like a girl problem to me."

Additionally, Sean expressed confusion and disbelief after receiving an ED diagnosis. At first as he felt that it did not apply to him:

At the beginning I think I was a little bit like standoffish because I was aware that I had depression but to have someone actually say you've got an eating disorder. ... I wasn't too happy about that because I didn't really believe them. ... I didn't realize that that was like an actual disorder that someone could have, so I didn't really think that they were understanding me at first.

Misunderstanding of Male-Specific Issues

A proportion of participants expressed feelings of frustration that they were misunderstood when being assessed, diagnosed, or treated. For example, Lucas expressed frustration with completing the Eating Disorder Examination Questionnaire diagnostic assessment measure as he did not feel it was relevant to the males generally or to his (male-specific) eating concerns. He stated:

I never found it useful because it would ask the same question five different ways. It was very female-oriented because it's asking, do I like the size of my hips? ... do I like the size of my thighs? And I just look at it and go, this doesn't apply to me so I'm like, no.

Additionally, Ben said that he did not feel that his anorexic eating behaviors were understood by his psychologist, who assumed that because he was male and not underweight, he wanted to be more muscular. Following engagement with a psychologist he stated:

I think when we focus on men, I still think there's this presumption by psychologists that the disorder is going be around muscle and wanting to look muscly ... but I still think there is some of that stuff of just wanting to be as small as physically possible ... for me it's like, I don't want muscles, I want to be so small that when I turn to the side I disappear.

Participants in Theme 2 described varied responses to their diagnosis, with some perceiving it as feminine and stigmatizing, while others struggled to accept it due to its perceived lack of relevance to male-specific concerns. Such responses highlight issues of resistance to diagnostic labeling and misunderstanding of male-specific issues which participants experienced within the ED assessment and treatment process.

Theme 3: Benefits of ED Treatment

In this theme, participants discussed the various approaches that their psychologist employed that helped them the most while undergoing ED treatment. These experiences are explored in subthemes related to the participants' appreciation of their treatment individualized to their specific capabilities and concerns, the rapport they developed with their psychologist, and specific components of ED treatment that they found particularly helpful.

Individualized Approach

A majority of participants reported that having treatment goals adjusted to their individual capabilities and needs allowed for increased ability to progress through stages of treatment. For instance, Mark acknowledged the benefits of his psychologist's flexibility in the treatment plan. He said that it was difficult for him to discuss personal concerns in front of his parents, but he found individual sessions with his psychologist were beneficial for his understanding of his ED:

It's just like having a genuine conversation. It let me vocalize my feelings and then after vocalizing them, I could sort of see them in a more open way. It also helped me to understand why I think certain things.

Additionally, some participants did not feel comfortable with their families participating in their sessions within family-based therapy and wanted privacy to discuss personal matters with their therapist. Participants shared that an individualized approach by their psychologist allowed them to articulate their emotions. For instance, Alex stated:

I think that was really important because otherwise I don't think I would have spoken about anything in front of my parents ... that would have just been too embarrassing for me. ... I didn't really talk about anything personal until I was just alone without them in the room ... so that was really helpful I was pretty grateful for that, that the psychologist did allow more time for that.

Rapport With Psychologist

During the study, participants were asked if they felt comfortable communicating their concerns with their psychologist and if they felt supported in treatment. The majority of study participants had positive relationships with their psychologists,

reporting that their psychologists were understanding and supportive in allowing them to work collaboratively. For instance, Alex expressed:

It's pretty good ... we can talk about things like vomiting and all of that kind of stuff but then we can also talk about my anxiety and ways to help that as well. I don't have to feel pressure just to talk about specific things ... we kind of leave it open and then go from there each session.

Some participants also reported that their psychologists were helpful in guiding family members to understand their experiences in session and that this was beneficial for recovery overall. Chris reported that his psychologist provided clarity for his parents, particularly for his father's understanding of his ED:

I think my psychologist was pretty good at getting my parents to understand that I was actually quite worried about getting lean ... rather than just thinking that I was just exercising because all my mates exercise. ... I think with dad, he does lots of exercise as well, so I think he just saw it as a positive thing ... they didn't realize that's actually why I was stressed ... so I think that was a really good part ... me trusting the psychologist to explain things and explain the cycle.

Helpful Treatment Components

A majority of the participants underwent family-based therapy in treatment. Treatment included family members and, wherever possible, involved parents in assisting adolescents in maintaining a balanced diet and eating schedule and in reducing disordered behaviors. Participants reported involving their families in their treatment was important in providing them with support and preventing them from engaging in ED behaviors. For example, Chris stated:

We did family treatment ... my parents were helping me to have meals without counting calories and without being so worried about if I'm eating too much or all the types of food ... mum would just prepare everything for me and then I would just have to eat it which was helpful for me because then I didn't have to worry about making the right choices all the time.

Similarly, Peter expressed that his family's involvement prevented him from engaging in disordered compensatory behaviors, such as purging after eating, as he stated, "It was good to have my parents there because that helped me to actually stop vomiting at times when I really wanted to." Some participants expressed that having family present also enabled them to talk about concerns that they would otherwise have had difficulty expressing due to anxiety or inability to accurately

describe their experiences. For example, Michael stated "I found that pretty helpful to have mum there because sometimes when I get nervous, I can't really say things too well so having mum there really helped me to talk more."

Some participants also discussed various aspects of the treatment they received including structured eating, reducing unhelpful behaviors such as binge eating, and learning about food groups. Regarding binge eating, in particular, Sean cited that portion control and learning about eating in moderation benefited him greatly:

Things like portioning ... an issue with my binging was that I would be eating straight from a source, like a jar of peanut butter. The psychologist said you know maybe put some aside like a piece of toast on the plate and then eat that portion first.

Exercise, which was utilized by some participants as a compensatory behavior, was also addressed during recovery. For instance, Ryan stated "I had to cut down on my exercise as well just because the amount I was doing was not helpful when I was trying to focus on my eating. ... I needed to stop the exercise to keep weight on."

Participants in Theme 3 reported an appreciation of individualized approaches tailored to their capabilities, the establishment of positive rapport with psychologists, and the effectiveness of treatment components, such as family-based therapy and structured eating. These elements facilitated open communication and collaboration between participants, their psychologists, and their families and helped to address specific ED behaviors like binge eating and excessive exercise during treatment.

Theme 4: Issues With ED Treatment

In this theme, participants discussed the aspects of their treatment plan that they disliked or found difficult to follow as well as concerns that they experienced with their treating psychologist. These experiences are explored in sub-themes related to the participants' experiences of feeling disconnected from their psychologist, as well as experiencing difficult adhering to specific ED treatment components or requirements.

Disconnection With Psychologist

As discussed in Subtheme Rapport with psychologist section, a majority of participants

felt supported and understood by their psychologists. However, some participants discussed experiencing negative interactions and comments from their psychologists. For instance, Kieran described feeling that his previous psychologist did not understand his concerns with eating and instead provided irrelevant information and strategies:

I didn't feel understood. I felt like she was providing insight into an issue that was not mine. I just felt like we weren't on the same page. ... I just remember it didn't feel right. I felt like it didn't really help. So, I felt like I was coming into the room and walking out confused.

Additionally, Ben stated that his psychologist made unhelpful comments by mentioning a goal weight number that Ben had previously disclosed drove his food restriction:

My psychologist ended up moving but before he left, he was like "goodbye and I hope you get to eighty kilos like you wanted." And I was like, that doesn't sound like something you're meant to say. ... Right, because we'd spoken about eighty as being a really rigid, bad number for me. ... I just felt really abandoned.

Difficulty Adhering to Treatment Components

Several participants mentioned constant supervision and monitoring of their eating by members of their family as a component that caused difficulty for them. As part of this monitoring, family members were often required to supervise meals that participants consumed at school. Peter stated that having his mother monitor his school meals had become embarrassing for him as it resulted in unwanted attention from his peers:

My friends found out that something was going on with me. ... I didn't tell them exactly what the problem was, but my mates would ask why I wouldn't eat with them and why I had to sit and eat with my mum at lunch, so that was embarrassing.

Lucas also expressed that, throughout treatment, he felt he that did not want his family to participate in the sessions or monitor and oversee his eating routines as it created tension at home, and he fought with his mother around mealtimes. He stated:

Not so much that it didn't work, but all the responsibility being put on mum, definitely strained our relationship. Because I mean, when someone's in that headspace like they just kind of lash out regardless of who it is. I mean it's a lot to put one person through, when they have to be the sole gatekeeper of your behaviors ... but if she didn't do it then I wasn't going to recover.

Additionally, while beneficial for recovery from an ED, participants expressed that they disliked having to immediately abstain from disordered behaviors once treatment began or engage in treatment components, such as increasing meal frequency and tracking weight gain or loss via weighing in session. For instance, Sean stated "I didn't really enjoy having to do weigh-ins ... because I found that pretty stressful and if it was different to what I expected I'd find it pretty hard not to want to stop eating again."

Similarly, Lucas, who was diagnosed with bulimia nervosa, was not permitted to use scales, which he previously used after eating. He found this difficult and stated "Cold turkey no scales whatsoever. ... I know it was necessary because I was at such a drastic weight, but having no scales was not a fun experience."

Participants in Theme 4 discussed their struggles with feeling disconnected from psychologists, instances of unhelpful comments, and experiences of a lack of understanding, which hindered their therapeutic progress. Moreover, they detailed the challenges of treatment components, such as constant family supervision of meals, immediate cessation of disordered behaviors, and strict restrictions like abstaining from using scales, all of which posed significant hurdles in their path to recovery from EDs.

Theme 5: Future Treatment Needs

In this theme, participants discussed their future treatment needs and made suggestions for changes to ED treatment approaches that they would consider helpful. These experiences are explored in subthemes related to the participants' understanding that they may need ongoing professional support for their ED as well as their opinions on changes to ED treatment that could be made to increase engagement and improve treatment outcomes for male adolescents.

Further Treatment Required

Most participants stated that they would still require a psychologist's assistance in the future, as they did not feel fully recovered from their ED. Despite reporting improvement, they believed that they still needed to work on translating their changed eating behaviors into everyday life and reengaging in social settings. For example, Peter stated:

I'm pretty okay. I've got to do a little bit more work around cutting down vomiting and eating a little bit more, so I'll probably see my psychologist for longer just because I haven't really got the hang of that just yet.

Similarly, Chris described wanting further treatment to enable him to better deal with difficult conversations with his peers and reengaging in social situations with his friends that involved eating:

I still probably need some help with eating out with friends especially because they are still going to talk about their gym progress and eating certain things ... they all still talk about it even now in group messages and things like that, so I think I'll probably need some more support with just trying to ignore that.

Tailored Treatment for Males

When asked about future treatment needs, a consistent theme that emerged among participants was the desire for more tailored treatments for male-specific issues. Suggestions included developing male-only treatment groups to assist participants to feel more validated within ED treatment settings and developing interventions in response to male-specific disordered eating characteristics. For example, Peter stated "It's pretty hard as a guy so maybe just like giving me different ways to feel better about my body or healthier ways to do that would probably be a good idea."

Ben also expressed a desire for current treatment methods to be more inclusive of males and males-specific characteristics in order that he could feel more validated within treatment settings:

I think the only thing is just the importance of intervention to really be framed around males, like I've never met another man who has an eating disorder. ... I've never spoken about an eating disorder with another man, and I still really think a lot of the imagery that we have around eating disorder recovery is framed around women.

Some participants felt that knowing other males with EDs or attending male-only treatment settings may have helped them discuss their concerns without feeling judged or isolated. For instance, Alex mentioned feeling embarrassed about discussing his ED in treatment:

I found it really hard to talk about my problems because I don't know any other guy that vomits their food up. ... I don't know any other guy that just doesn't eat ... my mates eat so much food, so it was embarrassing for me to actually admit what I was doing.

Similarly, Lucas described feeling isolated in treatment due to his diagnoses and not knowing other males with anorexia or bulimia:

I don't know anyone else that's a male that has either of these problems. ... I mean, I have female friends that have eating disorders but when it comes to male friends I was like, no. So, I already knew when I was coming in, I was like, I'm part of a very small minority just because I have Bulimia. But then being both bulimic and anorexic, I would be in an even smaller percentage of guys.

Participants in Theme 5 expressed ongoing treatment needs for their EDs, emphasizing the necessity for continued professional support to address lingering challenges. They also highlighted the need for tailored treatments specifically designed for male adolescents, emphasizing the importance of validation and inclusivity within treatment settings.

Discussion

The aim of this study was to investigate the experiences of male adolescents undergoing treatment for an ED. Ten male adolescents from two private psychology practices in New South Wales, Australia, were interviewed individually. Through framework analysis, five themes were identified (a) identification of the ED, (b) diagnosis of the ED, (c) benefits of ED treatment, (d) issues with ED treatment, and (e) future treatment needs. In addition, several subthemes emerged that outlined distinctive challenges for male adolescents seeking treatment for an ED, which reflect studies of male adults, including experiencing resistance to ED diagnoses, misconceptions regarding male-specific issues, a sense of disconnection with psychologists, and a desire for tailored treatment geared toward male adolescents (Thapliyal et al., 2020). A notable theme of the analysis was that the male adolescents' experience of ED treatment were significantly influenced by their ED diagnosis, the benefits and/or challenges they encountered during treatment, the rapport established with their psychologists, and the availability of tailored approaches to address their specific concerns.

Participants generally reported that the impact of receiving an ED diagnosis was less than positive. For many, it was related to perceived stigma about EDs, the perception that EDs were a "girls' problem," as well as reticence to disclose ED behaviors to health professionals to avoid diagnosis. Such findings reflect the principles of the sociocultural theory, which emphasizes the role of societal factors in the development of EDs

(Thompson et al., 1999). In this way, the resistance of male adolescents to ED diagnoses and the perception that gender roles dictate male self-reliance and resilience may point to the societal expectations that hinder male adolescent help seeking for EDs (Griffiths et al., 2015; Grillot & Keel, 2018). Indeed, findings by Räsänen and Hunt (2014) indicate that males frequently delay seeking treatment for ED symptoms and have difficulty recognizing them as a problem for these reasons (Griffiths et al., 2015; Grillot & Keel, 2018).

Additionally, participants also felt that their specific eating concerns were misunderstood or not reflected in assessment or treatment. While one participant, Ben, expressed that he desired a “small” body as part of his ED, another participant, Lucas, directly questioned the relevance of the Eating Disorder Examination Questionnaire (Fairburn & Beglin, 2008). These findings raise questions about the assumptions underlying current treatment models, their applicability to male adolescents, and the requirement in some jurisdictions to meet thresholds for an ED on the basis of specific psychometric assessment measures (Fairburn & Beglin, 2008). They also have implications for patient rebates in public health systems, for instance in the Australian Medicare system (Lavender et al., 2017). As such, while some foundational aspects of the transdiagnostic model may be appropriate for some adolescent male presentations, some may not be. For instance, the overvaluation of a “thin” body, a fear of weight gain, and the use of compensatory behaviors to prevent weight gain may not accurately capture male-specific ED concerns, such as a desire for muscle gain or ED behaviors related to gaining muscle mass (Lavender et al., 2017). Thus, in assessing and diagnosing male adolescents with EDs, health professionals may benefit from increased awareness of male-specific ED symptoms outside those stipulated by current theoretical models (Ganson et al., 2021). Similarly, broader assessment of male adolescents who present with psychiatric comorbidities may also be warranted in the interests of accurate diagnosis and differential diagnosis (Burton et al., 2022).

Male adolescents’ experiences of treatment appear to be determined largely by their relationship with their psychologist. Where treatment was considered beneficial by participants, they often cited an appreciation of the rapport that they developed with their psychologists and the use of

individualized approaches in their treatment. In this way, participants felt they could express emotions that they would otherwise have had difficulty doing in front of their families. While family-based therapy is the first line evidence-based treatment for adolescents with anorexia nervosa or atypical anorexia nervosa as per the Royal Australian and New Zealand College of Psychiatrists guidelines (Hay et al., 2014), this finding echoes those of Thapliyal et al. (2017), who reported that the utilization of collaborative therapy strategies and therapist knowledge, care, and trustworthiness were among the most important elements in male ED treatment experiences. Male adolescents engagement in ED treatment may result not only from the rapport and encouragement they experience but also to the extent that these aspects result in beneficial change (Dearden & Mulgrew, 2013; Thapliyal et al., 2020).

Where treatment was considered unhelpful or even detrimental by participants, they cited negative interactions with their psychologist that generally involved a misunderstanding about, or minimization of, their ED symptoms. Some male adolescents also reported that particular comments made by their psychologist were unhelpful for their recovery, which Robinson et al. (2013) suggested may be attributed to a minimization of concern that occurs among health professionals, particularly toward males seeking help for an ED. Interactions such as these may be problematic because they perpetuate gender role assumptions, for instance that males respond to mental health issues on their own. They may also decrease the likelihood that treatment will be accessed by male adolescents with EDs (Fatt et al., 2020; Griffiths et al., 2015). As such, ongoing professional development for mental health professionals working in the area of male adolescent EDs may assist in creating safe spaces in which male adolescents can discuss concerns such as DE or body image concerns (Ganson et al., 2021). In this way, knowledge of the unique and shared characteristics of adolescent male ED presentations may be improved, and more effective treatment for male adolescents with EDs may be developed (Ganson et al., 2021; Thapliyal et al., 2017).

Finally, when given the opportunity to discuss their future treatment needs, participants expressed a desire for more male-focused treatment components and settings. These requests were mainly attributed to a desire to feel less isolated as a young male experiencing an ED and receive treatment that was framed around male-specific concerns. Treatment groups comprised solely of

males may help male adolescents diagnosed with EDs to feel less isolated than they reported when participating in groups with a majority of female patients (Dearden & Mulgrew, 2013; Thapliyal et al., 2020). Feelings of isolation and perceptions of stigma may be lessened in treatment groups where male adolescents feel safe discussing their struggles with food and body image (Strother et al., 2012; Thapliyal et al., 2020). In addition, health practitioners treating male adolescents with EDs may need to consider challenging masculine ideals of strength, power, and control that coincide with eating difficulties, to better focus ED treatment on male-specific eating concerns (Thapliyal et al., 2017, 2020). Consequently, male adolescents may feel less isolated in seeking ED treatment and maintain engagement in treatment longer if their experiences are normalized (Dearden & Mulgrew, 2013; Thapliyal et al., 2020).

Limitations

When interpreting findings of the present study, certain limitations must be acknowledged. First, despite the presence of a range of EDs in the current sample, the study's limited size hindered its capacity to compare experiences of symptoms and ED treatment approaches across different diagnoses. Second, clinical assessment requires a level of psychological insight to be able to accurately capture an individual's state. The findings of this study may be limited by the adolescent-level insight that the participants had into what constituted DE, what their symptoms were, and what to expect from treatment. Findings may be further limited through the limited insight male participants may have into the symptoms of an ED and their own eating behaviors (Burton et al., 2022; Fatt et al., 2020). Third, while the study's findings may also apply to male adolescents undergoing ED treatment within countries other than Australia, future comparative studies may be required to capture a broader age range and a larger number of males. This should include early adolescent or young adult males from various countries with diverse health care and ED treatment approaches to provide a more comprehensive understanding of the experiences of male adolescents undergoing ED treatment. Finally, we did not offer participants the opportunity to review their interview

transcripts for reliability purposes, which could have enhanced the rigor of the study (Doyle, 2007). Despite recognizing the potential benefits of member checking, the logistical constraints in maintaining communication with the participants due to their ongoing treatment and potential confidentiality concerns prevented us from doing so.

Implications for Research and Clinical Practice

In light of the findings of the present study, it is crucial that future research further investigates the impact of the therapeutic relationship, diagnostic labeling, and male-specific treatment settings on the experiences of young male adolescents seeking treatment for an ED. Future research may also investigate the potential benefits of male-only ED treatment programs and male-specific ED information to increase engagement in treatment and foster greater acceptance of ED as a problem relevant to male adolescents (Dearden & Mulgrew, 2013; Thapliyal et al., 2020).

In addition, these findings may help to inform training programs for GP's and psychologists to increase awareness of male-specific ED symptoms, the challenges male adolescents face when attempting to seek treatment, and the need for normalization and validation of the male adolescents' experience (Ganson et al., 2021). Such training might emphasize heightened attention and increased awareness of male-specific ED symptoms beyond those outlined in current theoretical models and assessed by existing ED psychometric measures, such as desires for increased muscularity. Therefore, it is suggested that health professionals challenge the masculine ideals of strength, power, and control linked with eating challenges (Thapliyal et al., 2018).

This approach aims to enhance the treatment of EDs by focusing on the specific concerns related to males (Thapliyal et al., 2020). It also seeks to establish safe spaces for adolescent boys to openly address sensitive topics, such as DE or body image concerns (Ganson et al., 2021). In this way, the identification of male adolescents with EDs may be increased, and the stigmatization and isolation of male adolescents within ED treatment services and the wider community may be reduced, resulting in an improvement in overall treatment outcomes.

Conclusion

Ultimately the goal of such research is to contribute to a greater awareness of the unique experiences of male adolescents undergoing treatment for an ED. Importantly, this research underscores the significance of diagnostic labeling, personalized treatment methods, and the relationship dynamics with psychologists in the treatment process for male adolescents with EDs. These factors can either enhance or hinder their progress, engagement, and feelings of stigma and isolation during treatment. Additionally, the wider availability of male-specific ED information, treatment strategies, and treatment groups may also lead to higher engagement of male adolescents in ED treatment. This outcome may assist to reduce perception of EDs as a female disorder, reduce stigma attached to EDs treatment, and improve treatment engagement and outcomes for male adolescents.

References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.).
- American Psychological Association. (2020). *Publication manual of the American Psychological Association* (7th ed.). <https://doi.org/10.1037/0000165-000>
- Bitsch, V. (2005). Qualitative research: A grounded theory example and evaluation criteria. *Journal of Agribusiness*, 23(1), 75–91. <https://doi.org/10.22004/ag.econ.59612>
- Bowen, G. A. (2009). Supporting a grounded theory with an audit trail: An illustration. *International Journal of Social Research Methodology: Theory & Practice*, 12(4), 305–316. <https://doi.org/10.1080/13645570802156196>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, 18(3), 328–352. <https://doi.org/10.1080/14780887.2020.1769238>
- Burton, A. L., Hamilton, B., Iorfino, F., La Monica, H. M., Scott, E. M., & Hickie, I. B. (2022). Examining the prevalence of disordered eating in a cohort of young Australians presenting for mental health care at a headspace centre: Results from a cross-sectional clinical survey study. *BMJ Open*, 12(8), Article e061734. <https://doi.org/10.1136/bmjopen-2022-061734>
- Butterfly Foundation. (2017). *National agenda for eating disorders 2017–2022*. <https://butterfly.org.au/wp-content/uploads/2020/05/National-Agenda-for-Eating-Disorders-2018.pdf>
- Byrne, S. E., Basten, C. J., & McAlloon, J. (2023). The development of disordered eating in male adolescents: A systematic review of prospective longitudinal studies. *Adolescent Research Review*. Advance online publication. <https://doi.org/10.1007/s40894-023-00217-9>
- Carey, M., Kupeli, N., Knight, R., Troop, N. A., Jenkinson, P. M., & Preston, C. (2019). Eating Disorder Examination Questionnaire (EDE-Q): Norms and psychometric properties in U.K. females and males. *Psychological Assessment*, 31(7), 839–850. <https://doi.org/10.1037/pas0000703>
- Coffino, J. A., Udo, T., & Grilo, C. M. (2019). Rates of help-seeking in US adults with lifetime DSM-5 eating disorders: Prevalence across diagnoses and differences by sex and ethnicity/race. *Mayo Clinic Proceedings*, 94(8), 1415–1426. <https://doi.org/10.1016/j.mayocp.2019.02.030>
- Creswell, J. W., & Clark, V. L. P. (2017). *Designing and conducting mixed methods research*. Sage Publications.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, 39(3), 124–130. https://doi.org/10.1207/s15430421ti3903_2
- Darcy, A. (2011). Eating disorders in adolescent males: An critical examination of five common assumptions. *Adolescent Psychiatry*, 1(4), 307–312. <https://doi.org/10.2174/2210676611101040307>
- Dearden, A., & Mulgrew, K. E. (2013). Service provision for Men with eating issues in Australia: An analysis of Organisations', Practitioners', and Men's experiences. *Australian Social Work*, 66(4), 590–606. <https://doi.org/10.1080/0312407X.2013.778306>
- DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health*, 7(2), Article e000057. <https://doi.org/10.1136/fmch-2018-000057>
- Doyle, S. (2007). Member checking with older women: A framework for negotiating meaning. *Health Care for Women International*, 28(10), 888–908. <https://doi.org/10.1080/07399330701615325>
- Fairburn, C. G., & Beglin, S. J. (2008). Eating Disorder Examination Questionnaire (EDE-Q 6.0). In C. G. Fairburn (Ed.), *Cognitive behavior therapy and eating disorders* (pp. 309–314). Guildford Press.
- Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A “transdiagnostic” theory and treatment. *Behaviour Research and Therapy*, 41(5), 509–528. [https://doi.org/10.1016/S0005-7967\(02\)00088-8](https://doi.org/10.1016/S0005-7967(02)00088-8)

- Fatt, S. J., Mond, J., Bussey, K., Griffiths, S., Murray, S. B., Loneragan, A., Hay, P., Trompeter, N., & Mitchison, D. (2020). Help-seeking for body image problems among adolescents with eating disorders: Findings from the EveryBODY study. *Eating and Weight Disorders*, 25(5), 1267–1275. <https://doi.org/10.1007/s40519-019-00759-9>
- Forrest, L. N., Smith, A. R., & Swanson, S. A. (2017). Characteristics of seeking treatment among U.S. adolescents with eating disorders. *International Journal of Eating Disorders*, 50(7), 826–833. <https://doi.org/10.1002/eat.22702>
- Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology*, 13(1), Article 117. <https://doi.org/10.1186/1471-2288-13-117>
- Ganson, K. T., Murray, S. B., & Nagata, J. M. (2021). Last word: A call to develop specific medical treatment guidelines for adolescent males with eating disorders. *Eating Disorders*, 29(4), 344–350. <https://doi.org/10.1080/10640266.2019.1652474>
- Garner, D. M. (2004). *The Eating Disorders Inventory-3: Professional manual*. Psychological Assessment Resources.
- Girz, L., Robinson, A. L., & Tessier, C. (2014). Is the next generation of physicians adequately prepared to diagnose and treat eating disorders in children and adolescents? *Eating Disorders*, 22(5), 375–385. <https://doi.org/10.1080/10640266.2014.915692>
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105–112. <https://doi.org/10.1016/j.nedt.2003.10.001>
- Griffiths, S., Mond, J. M., Li, Z., Gunatilake, S., Murray, S. B., Sheffield, J., & Touyz, S. (2015). Self-stigma of seeking treatment and being male predict an increased likelihood of having an undiagnosed eating disorder. *International Journal of Eating Disorders*, 48(6), 775–778. <https://doi.org/10.1002/eat.22413>
- Grillot, C. L., & Keel, P. K. (2018). Barriers to seeking treatment for eating disorders: The role of self-recognition in understanding gender disparities in who seeks help. *International Journal of Eating Disorders*, 51(11), 1285–1289. <https://doi.org/10.1002/eat.22965>
- Hay, P., Chinn, D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S., Ward, W., & the Royal Australian and New Zealand College of Psychiatrists. (2014). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. *Australian and New Zealand Journal of Psychiatry*, 48(11), 977–1008. <https://doi.org/10.1177/0004867414555814>
- IBM Corp. (2020). *IBM SPSS statistics for windows* (Version 27.0).
- King, N., & Brooks, J. (2018). Thematic analysis in organisational research. In C. Cassell, A. L. Cunliffe, & G. Grandy (Eds.), *The SAGE handbook of qualitative business and management research methods: Methods and challenges* (Vol. 2, pp. 219–236). Sage Publications.
- Kinnaird, E., Norton, C., Pimblett, C., Stewart, C., & Tchanturia, K. (2019). “There’s nothing there for guys.” Do men with eating disorders want treatment adaptations? A qualitative study. *Eating and Weight Disorders*, 24(5), 845–852. <https://doi.org/10.1007/s40519-019-00770-0>
- Koch, T. (1994). Establishing rigour in qualitative research: The decision trail. *Journal of Advanced Nursing*, 19(5), 976–986. <https://doi.org/10.1111/j.1365-2648.1994.tb01177.x>
- Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy*, 45(3), 214–222. <https://doi.org/10.5014/ajot.45.3.214>
- Lavender, J. M., Brown, T. A., & Murray, S. B. (2017). Men, muscles, and eating disorders: An overview of traditional and muscularity-oriented disordered eating. *Current Psychiatry Reports*, 19(6), Article 32. <https://doi.org/10.1007/s11920-017-0787-5>
- Li, D. (2004). Trustworthiness of think-aloud protocols in the study of translation processes. *International Journal of Applied Linguistics*, 14(3), 301–313. <https://doi.org/10.1111/j.1473-4192.2004.00067.x>
- Lietz, C. A., & Zayas, L. E. (2010). Evaluating qualitative research for social work practitioners. *Advances in Social Work*, 11(2), 188–202. <https://doi.org/10.18060/589>
- Limbers, C. A., Cohen, L. A., & Gray, B. A. (2018). Eating disorders in adolescent and young adult males: Prevalence, diagnosis, and treatment strategies. *Adolescent Health, Medicine and Therapeutics*, 9, 111–116. <https://doi.org/10.2147/AHMT.S147480>
- Lincoln, Y. S., & Guba, E. G. (1982). *Establishing dependability and confirmability in naturalistic inquiry through an audit* [Paper presentation]. Annual Meeting of the American Educational Research Association, New York, NY, United States. <https://files.eric.ed.gov/fulltext/ED216019.pdf>
- Lincoln, Y. S., Guba, E. G., & Pilotta, J. J. (1985). Naturalistic inquiry. *International Journal of Intercultural Relations*, 9(4), 438–439. [https://doi.org/10.1016/0147-1767\(85\)90062-8](https://doi.org/10.1016/0147-1767(85)90062-8)
- Lindvall Dahlgren, C., Wisting, L., & Rø, Ø. (2017). Feeding and eating disorders in the DSM-5 era: A systematic review of prevalence rates in non-clinical male and female samples. *Journal of Eating Disorders*, 5(1), Article 56. <https://doi.org/10.1186/s40337-017-0186-7>

- Linville, D., Benton, A., O'Neil, M., & Sturm, K. (2010). Medical providers' screening, training and intervention practices for eating disorders. *Eating Disorders, 18*(2), 110–131. <https://doi.org/10.1080/10640260903585532>
- Linville, D., Brown, T., & O'Neil, M. (2012). Medical providers' self perceived knowledge and skills for working with eating disorders: A national survey. *Eating Disorders, 20*(1), 1–13. <https://doi.org/10.1080/10640266.2012.635557>
- Lumivero. (2020). *NVivo12*. <https://lumivero.com/products/nvivo/>
- Madden, S., Morris, A., Zurynski, Y. A., Kohn, M., & Elliot, E. J. (2009). Burden of eating disorders in 5–13-year-old children in Australia. *The Medical Journal of Australia, 190*(8), 410–414. <https://doi.org/10.5694/j.1326-5377.2009.tb02487.x>
- Mitchison, D., Mond, J., Bussey, K., Griffiths, S., Trompeter, N., Lonergan, A., Pike, K. M., Murray, S. B., & Hay, P. (2020). DSM-5 full syndrome, other specified, and unspecified eating disorders in Australian adolescents: Prevalence and clinical significance. *Psychological Medicine, 50*(6), 981–990. <https://doi.org/10.1017/S0033291719000898>
- Mitrofan, O., Petkova, H., Janssens, A., Kelly, J., Edwards, E., Nicholls, D., McNicholas, F., Simic, M., Eisler, I., Ford, T., & Byford, S. (2019). Care experiences of young people with eating disorders and their parents: Qualitative study. *BJPpsych Open, 5*(1), Article e6. <https://doi.org/10.1192/bjpo.2018.78>
- Murray, S. B., Griffiths, S., & Mond, J. M. (2016). Evolving eating disorder psychopathology: Conceptualising muscularity-oriented disordered eating. *The British Journal of Psychiatry, 208*(5), 414–415. <https://doi.org/10.1192/bjp.bp.115.168427>
- Murray, S. B., Griffiths, S., & Nagata, J. M. (2018). Community-based eating disorder research in males: A call to action. *Journal of Adolescent Health, 62*(6), 649–650. <https://doi.org/10.1016/j.jadohealth.2018.03.008>
- Murray, S. B., Nagata, J. M., Griffiths, S., Calzo, J. P., Brown, T. A., Mitchison, D., Blashill, A. J., & Mond, J. M. (2017). The enigma of male eating disorders: A critical review and synthesis. *Clinical Psychology Review, 57*, 1–11. <https://doi.org/10.1016/j.cpr.2017.08.001>
- Nagata, J. M., Carlson, J. L., Golden, N. H., Long, J., Murray, S. B., & Peebles, R. (2019). Comparisons of bone density and body composition among adolescents with anorexia nervosa and atypical anorexia nervosa. *International Journal of Eating Disorders, 52*(5), 591–596. <https://doi.org/10.1002/eat.23048>
- Onwuegbuzie, A. J., & Leech, N. L. (2007). Validity and qualitative research: An oxymoron? *Quality & Quantity: International Journal of Methodology, 41*(2), 233–249. <https://doi.org/10.1007/s11135-006-9000-3>
- Räisänen, U., & Hunt, K. (2014). The role of gendered constructions of eating disorders in delayed help-seeking in men: A qualitative interview study. *BMJ Open, 4*(4), Article e004342. <https://doi.org/10.1136/bmjopen-2013-004342>
- Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In A. Bryman & R. G. Burgess (Eds.), *Analyzing qualitative data* (pp. 173–194). Routledge. https://doi.org/10.4324/9780203413081_chapter_9
- Robinson, K. J., Mountford, V. A., & Sperlinger, D. J. (2013). Being men with eating disorders: Perspectives of male eating disorder service-users. *Journal of Health Psychology, 18*(2), 176–186. <https://doi.org/10.1177/1359105312440298>
- Rodgers, R. F., Franko, D. L., Lovering, M. E., Luk, S., Pernal, W., & Matsumoto, A. (2018). Development and validation of the Female Muscularity Scale. *Sex Roles: A Journal of Research, 78*(1), 18–26. <https://doi.org/10.1007/s11199-017-0775-6>
- Rodgers, R. F., Slater, A., Gordon, C. S., McLean, S. A., Jarman, H. K., & Paxton, S. J. (2020). A biopsychosocial model of social media use and body image concerns, disordered eating, and muscle-building behaviors among adolescent girls and boys. *Journal of Youth and Adolescence, 49*(2), 399–409. <https://doi.org/10.1007/s10964-019-01190-0>
- Smith, K. E., Mason, T. B., Murray, S. B., Griffiths, S., Leonard, R. C., Wetterneck, C. T., Smith, B. E. R., Farrell, N. R., Riemann, B. C., & Lavender, J. M. (2017). Male clinical norms and sex differences on the Eating Disorder Inventory (EDI) and Eating Disorder Examination Questionnaire (EDE-Q). *International Journal of Eating Disorders, 50*(7), 769–775. <https://doi.org/10.1002/eat.22716>
- Spillett, M. A. (2003). Peer debriefing: Who, what, when, why, how. *Academic Exchange Quarterly, 7*(3), Article 36.
- Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating disorders in men: Underdiagnosed, undertreated, and misunderstood. *Eating Disorders, 20*(5), 346–355. <https://doi.org/10.1080/10640266.2012.715512>
- Thapliyal, P., Conti, J., Bandara, R. S., & Hay, P. (2020). "It exists": An exploratory study of treatment experiences in men with eating disorders. *Australian Psychologist, 55*(5), 534–545. <https://doi.org/10.1111/ap.12455>
- Thapliyal, P., Hay, P., & Conti, J. (2018). Role of gender in the treatment experiences of people with an eating disorder: A metasynthesis. *Journal of Eating Disorders, 6*(1), Article 18. <https://doi.org/10.1186/s40337-018-0207-1>
- Thapliyal, P., Mitchison, D., & Hay, P. (2017). Insights into the experiences of treatment for an

- eating disorder in men: A qualitative study of autobiographies. *Behavioral Sciences*, 7(2), Article 38. <https://doi.org/10.3390/bs7020038>
- Thompson, J. K., Heinberg, L. J., Altabe, M., & Tantleff-Dunn, S. (1999). *Exacting beauty: Theory, assessment, and treatment of body image disturbance*. American Psychological Association. <https://doi.org/10.1037/10312-000>
- Vicary, S., Young, A., & Hicks, S. (2017). A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis. *Qualitative Social Work: Research and Practice*, 16(4), 550–565. <https://doi.org/10.1177/1473325016635244>
- Vo, M., Lau, J., & Rubinstein, M. (2016). Eating disorders in adolescent and young adult males: Presenting characteristics. *Journal of Adolescent Health*, 59(4), 397–400. <https://doi.org/10.1016/j.jadohealth.2016.04.005>
- Zoom Video Communications. (2016). *Security guide*. <https://d24cgw3uvb9a9h.cloudfront.net/static/81625/doc/Zoom-Security-White-Paper.pdf>

Received May 4, 2023
Revision received April 24, 2024
Accepted April 29, 2024 ■

E-Mail Notification of Your Latest Issue Online!

Would you like to know when the next issue of your favorite APA journal will be available online? This service is now available to you. Sign up at <https://my.apa.org/portal/alerts/> and you will be notified by e-mail when issues of interest to you become available!