WHY ARE THEY UNWILLING TO GROW UP?
FAMILY THERAPY WITH ANORECTIC MALES

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Abstract: The prevalence of anorexia nervosa is increasing among males. However, there are only a few studies on the family therapy of eating disordered males. In this paper three case reports are presented, where the significant remission was due to family therapy. In the development of the symptoms the postadolescence described by Keniston was in the foreground in two patients. This phenomenon is increasing in the last decades, and may serve as a risk factor of late onset anorexia in males. Family therapy can be the method of choice in postadolescent males as well, because in spite of the late onset, the family dynamics are similar to that found in the family of adolescent anorectics. This paper examines the similar and different aspects of family therapy of male and female patients with anorexia nervosa. In the family therapy of male anorectic patients only a few gender specific characteristics were found.

Key words: eating disorders, anorexia nervosa, males, family therapy, postadolescence
Background
Formerly eating disorders were regarded as the disorders of white Western women (“3W”). This is less valid in the last decades, as the prevalence of eating disorders is increasing among non-white people, in non-Western countries and among males. Males with eating disorders have been reported since 1689, when Morton [1] published two cases, one of them was a male patient with “nervous consumption”.

The proportion of males in the total number of eating disordered subjects is about 10%, and most studies on eating and body image disorders have included female samples. As a consequence, little is known about men’s eating patterns [2]. It is likely that rates of eating disorders in males will continue to increase [3]. Because of the increasing number of male patients with an eating disorder there is an assumption that by the year 2050 the difference in the prevalence of eating disorders between males and females will disappear due to the great impact of the slimness ideal on males [4]. There are some subpopulations among males with a higher pressure towards thinness. For instance, body shape and thinness is much more emphasized among homosexual males than among heterosexuals. Some kinds of sports require thinness, and this may cause a very low body weight, for example, among jockeys and dancers. The male anorexia is often hidden, because the doctors are less likely to think of it [5].

There are some differences between the characteristics of male and female anorexia. Females try to lose weight continuously, but males stop losing weight at a low but not life-threatening body weight. Serious cases can evidently occur in both sexes. There is a book written by a seriously and chronically underweight male patient from the United States. He died after the second edition of his book [6]. Lowenstein [7] described the following predisposing factors and characteristics of male eating disorders: overdependence from the family; wrong identification with the father; close relationship with the mother; open malignity between father and son; too much worries because of weight; physical diseases, e.g. Crohn disease; high intelligence and good achievement at school; depression; low sexual interest, low level of testosterone, conflicts about homosexuality, general sexual anxiety; psychotic disorder; anxiety; overweight parents; restricted anger; too much dealing with food; obsessive traits and perfectionism.

Ousley et al. [2] in comparing 750 males and 750 females concluded that males with an eating disorder were less fearful about gaining weight and becoming fat, or heavy, than females with an eating disorder. However, Woodside et al [8] reported that men with eating disorders had higher rates of comorbid psychiatric diagnoses compared to men without eating disorders. Similar to females, males have increased rates of different psychiatric diseases, e.g., depression, anxiety disorders, and addictive disorders. The metabolic consequences are also frequent, such as the osteoporosis. Males with eating
disorders tend to externalize emotional distress, and cannot easily express their emotional state, or talk about their life events [3].

According to family dynamic observations, since the 1970s, it has been suggested that family therapy is one of the most important treatment options for patients, with anorexia nervosa. Later on, it was proposed in the treatment of bulimic patients, as well. Now, it is regarded as one of the major therapeutical methods in the treatment of adolescents with an eating disorder [9]. The family can be regarded as a resource of the treatment. For teenagers family therapy is the first-choice treatment method (not the pharmacotherapy). Controlled trials support the effectiveness of family therapy, as well [10].

So far, there are only few publications about the family therapy of eating disordered males. In the first case report, Carr et al, [11] described the successful family therapy combined with behaviour therapy, where the separation-individuation process was in the foreground. Rechlin et al [12] presented a case study of a 22-year-old male patient. They stress the importance of the family system in the motivation for the loss of weight. Besides the individual diagnostic measures, several family tests were used as well (the Family Sculpture Test, the Thematic Apperception Test, the Family Interview, and the Family Rorschach Test). The authors underline the significance of cohesion, adaptability, the outer boundaries of the system, rules and norms within the family, and generational boundaries.

Lately, we have also published a case report of a 19-year-old male patient living in a patchwork family [13]. In this paper a 10-session long family therapy was described, and the reorganization of the family was in the focus. In our institute the family therapy is a central therapeutical modality in the treatment of eating disorders, and in the last years an increasing number of male patients sought treatment. This article will summarize the main characteristics of the family therapy of three male patients with anorexia nervosa.

**Case vignettes**

**Case 1**

The 30-year-old Robert (pseudonym) was an only child, who lived separately from his parents, but was employed in the car service of his parents, and received salary from his father, although he had no duties at all. His mother was talkative and overprotective, his father occasionally impulsive, did not define the job of supportive his son, accepting that as parents they should support their son. He has had a girlfriend, for three years, and a degree in a technological college.

Robert’s maximum weight ever was 67 kg, at the time when he did bodybuilding. He started to lose weight two years ago. After a phone call the family therapy was proposed. His parents were worried about Robert’s health. He spent most of his time with his parents, with whom he had fierce quarrels, because they considered him as a child. Robert’s mother cried sev-
eral times. They wanted Robert to continue the work in the company, but he was too weak to participate, and he did not show any willingness to work. He enjoyed his parents’ unconditional support.

At the first interview he was like an underweight, defying adult-baby (height: 180 cm, weight: 45 kg, BMI: 13.9). He had also obsessive symptoms (checking continuously his temperature and clothing), so he had been treated with an antidepressant (citalopram) for a few months. The diagnosis was anorexia nervosa, with a comorbidity of obsessive-compulsive disorder.

During the 22-session family therapy and pharmacotherapy (20 mg citalopram daily) his obsessive symptoms disappeared, he started to take responsibility for his issues: he could manage to pay the bills of his flat, performed his personal duties, and started to put on weight slowly (one kilogram per month). Meanwhile, he broke up with his girlfriend, but later, they reconciled although he had quarrels with his mother, she became considerably less overprotective. The hardest task was to make his father understand Robert’s needs to have important and real duties at their company. The breakthrough was brought about by the entrance of a young worker with whom Robert started to work together, and he became self-sufficing.

Robert changed his appearance, lately he has looked like a grown-up man. By the three-month follow-up he has gained 17 kilograms (body weight: 62 kilograms, BMI: 19.1). He was ready to increase his body weight. He was more involved in his parents’ company, he had important duties and responsibilities. He could deal with the problematic issues in his relationship with his girlfriend, and they plan to marry.

In summary, a significant, but partial remission could be observed. The family therapy intervention was focused on the adult role of the patient, and the separation-individuation process.

**Case 2**

The 22-year-old Jonas (pseudonym) was an only child, living with his parents. He had an elder brother who lived separately. His mother was a housewife, his father was a businessman in a technological company.

At the time of the first interview, Jonas was a slow, underweight, and childish boy (height: 185 cm, weight: 54 kg, BMI: 15.8). He studied information technology at the university in the town where they lived. He has had an insulin dependent diabetes mellitus for 8 years. Besides that, he has had obsessive-compulsive symptoms from his childhood, aggressive and sexual obsessions, and hand washing. He began to lose weight two years before treatment. He was hospitalized a year ago, and regained only a few kilograms. He ate a little bit, but he had also a chewing and spitting out syndrome. Because of the obsessive symptoms, he has been treated with pharmacotherapy (10 mg olanzapine and 10 mg citalopram daily) by a psychiatrist. He did not perceive himself as underweight, and he was worried about
being overweight. The diagnosis was anorexia nervosa, diabetes mellitus, and obsessive-compulsive disorder.

His mother was overprotective, spending the most of the time at home. His father worked a lot, often absent from their home. They described Jonas as a silent person who was frequently bored, so he wanted to spend all his time with his mother, which was a pressure for her. The mother cried a lot due to her worry about Jonas’s physical status while the father did not understand why his son could not recover. Jonas was isolated, had no girlfriend in his life, and had only superficial relationships with his university colleagues.

The aim of the family therapy was to strengthen the separation of Jonas, to decrease the overprotectiveness of the mother, and to involve the father more in the family affairs. There was tension between the parents, because the mother wanted to discuss the family problems with her husband, who refused that.

The family therapy lasted for four months, and consisted of 10 sessions. At the two-month follow-up, the mother was less overprotective, and the father spent more time with the family. They reciprocated favours, which helped to decrease the tensions in the family, and the family members became more attentive to each other. The diabetes of Jonas was stabilized. He began to take more responsibility for his body and weight. Chewing and spitting out occur sometimes. During the therapy, Jonas gained 15 kilograms, reaching the normal weight range, and was steadily 76 kilograms (BMI: 22.2) in the last weeks. Also, he became more active in the university, while his obsessive thoughts have decreased a little during the treatment. The family decided to follow the patient’s individual therapy in their home town because of the obsessive symptoms.

In this case, similarly to the former case, the stimulation of the separation-individuation process was in the foreground of the therapy. The isolation of the patient decreased, and he began to take more responsibility in his own life. It is important to mention that the combination of the diabetes and anorexia nervosa is very dangerous, sometimes fatal.

Case 3

The 20-year-old Rudolf (pseudonym) lived far from his family in a rented flat because he was a student at a pedagogic college. His mother was a housewife, his father was a driver. Rudolf was the first born child, and had a 16-year-old brother, who went to grammar school. Rudolf had a good relationship with his parents. His mother took care of the family, his father spent a lot of time working abroad.

One year before the family therapy began Rudolf had started a diet, because he was 80 kg and felt slightly overweight (height: 177 cm, BMI: 25.5). He wanted to be liked by women. He had never had a relationship with a girl, but had some friends. He was treated with vitamins and antidepressants by the family doctor, but he continued to lose weight. He practiced
long-distance running, and used an exercise bike. His weight loss was constant, and at the time of the first interview he weighed 47 kg (BMI: 15.0). He knew that he was too slim, and wanted to gain weight to reach 65 kg (this would be a BMI 20.7). Because the pharmacotherapy was not effective to gain weight, his mother looked for other treatment opportunities, so she found our outpatient department.

Rudolf was talkative, but his mother dominated the first interview, getting into details of the everyday life of her son, demonstrating her overprotectiveness and the enmeshment between them. The father was supportive, but peripheric, without paying enough attention to the illness of his son, spending the majority of the week abroad. Because of that, he could participate only three times in the treatment process.

The diagnosis was anorexia nervosa. The family engaged in family therapy, which lasted for four months, including seven sessions. There was a follow-up in e-mail after three months.

The aim of the therapy was to decrease the maternal overprotectiveness, to increase paternal involvement and to increase Rudolf’s self-confidence and his responsibility for his body. His health status was steadily improving, he became more open towards women, starting to attend some parties.

At the three-month follow-up, Rudolf had no symptoms, his body weight was 69 kg (BMI: 22.0). His relationship with his parents was harmonious, and he had a good social life. In this case, the process of the family therapy was essentially not different from the usual family therapy of female anorectic patients. The following issues were in the focus of the therapy: the self-confidence and the sexual anxiety of the patient, the structural characteristics of the family: maternal overprotectiveness, enmeshment, and the peripheric role of the father. The therapy ended with complete remission.

**Conclusion**

It is an open question, whether the family therapy of male anorects differs from that of females, and if yes, in which regard. There can be similar and different aspects. The importance of the separation-individuation process, and the role of the structural family dysfunctions can be similar – especially the maternal overprotectivity, and the peripheral situation of the father [14]. In our cases, many of these characteristics could have been observed.

The first two cases demonstrated that the patients did not want to take the responsibility for their adult life. It was comfortable for them to live with their family. Although the patient in the first case was in his 30s, he was supported by his parents, and his relationship with them was like a quarreling teenager-parents relationship. He had no plans to have his own family although he had a girlfriend. The patient in the second case was involved only in his university studies and his family, but no other social activities or sexual interest. In the third case, the desire for a relationship played a central role.
Sexuality related anxiety and dissatisfaction with the body was similar to the phenomena in female anorexia nervosa.

In each case, the strong Oedipal relationship with the mother was striking. This relationship was ambivalent: although the patients were in their adult age, and the maternal worry and overprotectiveness caused frustration for them, they did not want to lose that, so they lacked the healthy and normal desire to separate from parents. Instead pursuing autonomy they assumed the role of a child.

A key feature of male anorexia nervosa is that the rate of weight-loss is not life-threatening, and the patients are satisfied with the stabilized low body weight. Unlike females, male patients lacked the resistance for continuous weight loss, and this is the one of the reasons why males have a better relationship with their mothers than female patients. The female anorectics tend to exhibit opposition and resistance to their mother. Their weight loss is frightening to the father as well. The attention of the father is very important in terms of their personality development while the “anorectics” are “hungry for their fathers’ attention” as it was described in the literature [15].

In their overview, Brown and Keel [16], point out that the family based treatment of anorectic patients is advantageous because it balances the benefits of a controlled environment for producing weight gain with the external validity of achieving these aims within the home environment. In younger adolescent patients, who live with their family of origin, the family therapy proves to be the most effective treatment. Less evidence is available on the effectivity of family therapy in bulimic patients. One of the reasons is that the bulimia occurs a bit later, and the symptoms are frequently hidden [9,10].

Our patients were of postadolescent age (20-22-30 year old). There is an interesting phenomenon called “postadolescence among youths” which was first published by Keniston [17,18]. It can be characterized by the delay of accepting adult responsibilities. These young adults meet the psychological criteria of being adult, but they do not meet the sociological ones. The economic basis of independence and autonomy is missing.

This phenomenon covers up the following overdependence on the family; strong relationship with the mother; fights with the father; obsessive characteristics; perfectionism and, low sexual interest.

Kiecolt-Glaser and Dixon [19] reported four male cases of postadolescent onset anorexia, treated with individual therapy. The age patients at the onset of anorexia were 19-22 years. The authors suggest that postadolescent males seem to withdraw from the challenges of everyday living. They state that the withdrawal of these male patients from achievement and autonomy is a deviation from cultural sex-role norms. This may be the cause of the poorer outcome in comparison to females.

These males are afraid of having their own family, choosing the security of the parent's home which led them to the isolation. This is what distinguishes male anorexia nervosa from female anorexia nervosa also. Females
procrastinate growing-up too, but males may be afraid of different things, for example being the head of a family.

Today, the number of marriages decreases and the number of common-law marriages is growing. The other alternative to marriage, besides common-law marriage, is being single. The reason why males, who do not earn money and do not have a job, do not marry, is because they would not be able to maintain a family. Several sociological analysis support the idea that men lost they so called manlike behavior, and they are afraid assuming the role of the head of their own family. Parents have a remarkable role in the process of postponing growing up. The phenomenon of “lifelong parenting” is quite prevalent, which means that parents undertake the prolonged support of their children instead of stimulating their desire to become an independent adult [20].

According to the Hungarian data, 40 years ago 20% of adults below the age of 40 lived with their parents while this ratio was 40% in 2011. The reasons for this phenomenon are different: difficulties in buying a flat, the elongated time spent in higher education, difficulties in finding a job, and the decreased number of long-lasting relationships [21].

In the case of postadolescent females, the Oedipal relationship may be different from that of males. Mothers are the linchpins of a family, so the Oedipal relationship with the son can hold the son in the bond of the family more than in the case of daughters, because the Oedipal relationship of daughters with their fathers can be weak to hold the daughter in the bond of the family. As it was written in the case vignettes, the strong relationship between sons and mothers was the reason why the desire for independency was discouraged among them.

Family therapy is recommended for teenagers. Stressing the importance of postadolescence, eating disordered males in their 20s or even 30s seem to wish to stay teenagers forever – as Peter Pan did, who never wanted to grow up [22]. During the family therapy we realised that responsibility given to the patient helps the most. Besides, it was important to decrease the mother’s overprotectiveness and the emotional distance of the father from the family.

In summary we can say that in the family therapy of male anorectic patients, only a few gender specific characteristic could be found. Our first and second case was typical examples of the postadolescence. In spite of the late onset of illness, the family therapy was an important and effective method of their treatment. In the third case, no prominent gender specific characteristics could be found. In general, the therapy did not essentially differ from the family therapy of female anorectics. The further research of the gender specific features in the context of the family therapy of anorectics is essential, and may bring new aspects to the therapeutical process. This may be easier in the next decade, since the number of male anorectics is increasing.
ZAŠTO SU NEVOLJNI DA ODRASTU?
PORODIČNA TERAPIJA MUŠKARACA SA ANOREKSIJOM NERVOZOM

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**Apstrakt:** Prevalenca anoreksijske nervose je u porastu kod osoba muškog pola. Ipak, postoji mali broj studija učinka porodične terapije kod muškaraca sa poremećajem ishrane. U ovom radu predstavljena su tri slučaja koja su imala značajnu remisiju uz primenu porodične terapije. Kod dva pacijenta pozadini simptomatologije činila je postadolescencija opisana od strane Kenistona. Ovaj fenomen je u porastu poslednjih decenija i može predstavljati faktor rizika za anoreksiju nervozu kasnog početka kod muškaraca. Porodična terapija može biti metoda izbora kod postadolescentnih muškaraca jer je, uprkos kasnom početku razvoja poremećaja, porodična dinamika slična onoj koja se vida kod adolescenata sa anoreksijom. U ovom radu istražuju se sličnosti i razlike u primeni porodične terapije muških i ženskih pacijenata obolelih od anoreksije nervose. Otkriveno je svega nekoliko specifičnosti u vezi sa polnim razlikama prilikom primene porodične terapije kod muških pacijenata.

**Ključne reči:** poremećaji ishrane, anoreksija nervosa, muškarci, porodična terapija, postadolescencija
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