

**NARRATIVES OF
MALES WITH EATING DISORDERS**

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ABSTRACT

For years, eating disorders, particularly anorexia nervosa and bulimia nervosa, have been studied extensively among adolescent girls and young women. However, despite recent research revealing a significant percentage of men display behaviours related to eating disorders, their individual experiences remain relatively unstudied. Additionally, given the reality that many males usually conceal or deny having the disorder, few studies yielding *in-depth* accounts of their lived experiences have also not been completed. This study, however, examined, through narrative inquiry, the experiences of two young adult males who were medically diagnosed with and treated, or were presently being treated, for disordered eating. Though each was *not* impervious to societal and familial pressures to look and be perfect, such pressures, tragically, were exacerbated by the pronounced fear, and actual experience, of being stigmatized by helping professionals. These findings provide a preliminary understanding of the threat that disordered eating poses for males, irrespective of background and lifestyle. Aside from having implications for theory, these findings are also expected to contribute in ways that will help to inform the practices of counsellors and therapists in the field of psychology.

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With much love, I wish to dedicate this thesis to my parents, a continual source of strength and inspiration. The myriad of sacrifices you have generously made over the years in order for me to pursue my dream will never go unrecognized. I am forever indebted to you both. To Mom, thank you for your unconditional support and encouragement throughout my life. The pride you have taken in me means so much. To Dad, I am thankful for your wisdom and eternal optimism. My gravest of cares are calmed by your presence. Thank you for instilling in me the work ethic and confidence to succeed at whatever I choose to undertake. I continue to learn from your example.

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weap-on (wep'en)

n. **1** any instrument used in fighting;
means of attack or defence. **2** anything
viewed as similar to this in purpose or nature;
a means of attack or defence.

CHAPTER ONE

Introduction

Background

Eating disorders are among the few mental health problems in adolescence and young adulthood that affect females far more than males. Although a vast literature has repeatedly documented the features of women with eating disorders, data on eating disorders in men remain limited. Despite being mentioned among the first case presentations in the English language, males have been relatively ignored, neglected or dismissed in eating disturbance research because of statistical scarcity or theoretical bias (Andersen, 1995). More recent trends, however, “suggest that these disorders may be increasing in males, perhaps altered in form from the typical presentation in women” (Andersen, 1990a, p. ix). As such, there exists an increasing need, as psychologists and educators, to improve our recognition of eating disorders in this subculture and to focus more attention on the prevention and remediation of these disorders.

Few authors today would doubt the existence of eating disorders in the male and current diagnostic criteria allow males to be included (American Psychiatric Association, 2000; Andreasen & Black, 1995). However, it remains unknown as to what protects some males from developing eating disorders and what may predispose other males to develop them. Although the prevalence of eating disorders in males, in comparison to females, is less common, some of the variation in estimates of relative frequency in males may be accounted for by methodological difficulties (i.e., small sample sizes). Males are generally reported to account for 5-10% of anorectics (Andersen & Mickalide, 1983; Crisp & Burns, 1983; Sharp, Clark, Dunan, Blackwood, & Shapiro, 1994) and 10-15% of

all bulimic patients (Carlat & Camargo, 1991; Halmi, Falk, & Schwartz, 1981).

However, as Andersen, Cohn, and Holbrook (2000) recently reported, “it should not be surprising if closer to 25-30% of eating-disordered individuals are male, but there are only hints from early scientific data to confirm that figure” (p. 32).

Research suggests that a relatively small number of males identified within the general population seek professional assistance and treatment for the disorder. In many cases, male eating disorders remain underdiagnosed because those afflicted with the disorder may be too embarrassed to report their symptoms for fear that they will be considered “effeminate” (Pope, Phillips, & Olivardia, 2000). Most, if not all, men assume they are not vulnerable because of the prevailing view in the media that the disorder occurs only in young Caucasian women. Although Rand and Kuldau (cited in Tylka & Mezydlo Subich, 2002) have found that women indeed report more disordered eating behaviours than do men, the stereotype that only White women have eating disturbances may have led to the underrepresentation of men, older persons and non-Caucasian persons in research on eating disturbances (Andersen, 1995). Furthermore, concern about body shape in the absence of weight loss is not considered by the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* as characteristic of eating disturbances (Tylka & Mezydlo Subich, 2002). As a result, it is not explored much by researchers. Yet, according to Andersen and DiDomenico (1992), men often report being concerned about changing their body shape without reporting a desire to lose weight.

Similarly, as Scott (1986) reports, because some physicians may be unaware of the existence of eating disorders in males, they may be more likely to launch an extensive

inquiry into more obscure causes of weight loss. According to Andersen and Mickalide (1983), “clinicians may find it increasingly difficult to diagnose because its presentation in males may have features, such as emphasis on somatic complaints, that obscure the central psychopathological symptoms” (p. 1067). That is, their eating behaviour may be secondary to other psychiatric disorders.

Gender differences also exist in the labelling of behaviour. For example, Franco, Tamburrino, Carroll, and Bernal (cited in Furnham & Calnan, 1998) reported that males, in comparison to females, do not label ingestion of large quantities of food as bingeing. Andersen and colleagues (2000) concurred with this finding, reporting, “men eat with far less restraint in their food choices and quantities consumed” (p. 71). However, in those instances of binge eating, such behaviour may go unrecognized in males because an overeating male is less likely to garner attention than an overeating female. Diagnosis in males may additionally be confusing because of the words they commonly use to express their body dissatisfaction. As Andersen (1990b) reports, males do not often complain about how many pounds they weigh or the size of their clothes they wear. Instead, they are much more “worried about perceived abnormalities in body shape and form, and express intense desire to lose ‘flab’ and to achieve a more classical male definition of muscle groups” (p. 137).

The identification of problematic eating behaviours in males is further exacerbated by the non-existence of any apparent signal that alerts family and others to the medical consequences of severe weight loss (Andersen, 1999). In contrast to their female counterparts, males cannot manifest amenorrhea, an oft-reported clinical feature of anorexia nervosa. Whereas anorexia nervosa evinces itself as a publicly visible

disorder, the process of diagnosing bulimia nervosa is far more complicated because the disorder is often considered to be very private and secretive in nature (Andersen, 1990b). The concealing nature of male dress can also contribute to a disproportionately lower rate of diagnosis in the male (Crisp & Burns, 1983).

It is well documented that men are subjected to less social and media pressure to diet than are women (Andersen, 1990b; Andersen & DiDomenico, 1992; Carlat & Camargo, 1991; Leit, Gray, & Pope, 2002; Pope, Phillips, & Olivardia, 2000). Data obtained by Murray (1999) indicate that greater pressure occurs on women than on men to conform to societal body ideals. Furthermore, she continued by reporting that males were significantly less likely than females to report that the media had an influence on their body shape and weight-related attitudes and behaviours. Traditionally, “men’s esteem and self-identity have been based on multiple factors such as their intelligence, economic status, career, relationships, and physical prowess, whereas women’s identity has been determined primarily by how closely they match society’s contemporary beauty ideal” (Petrie & Rogers, 2001, p. 744).

According to Andersen (1999), “because there is less general cultural endorsement to diet, males tend to diet only when they are objectively heavier than average and commonly for four specific reasons: to avoid being teased again for childhood obesity, to increase sports performance, to avoid developing medical illnesses that they have seen in their fathers related to weight, or to improve a gay relationship” (p. 216). From the available findings, it appears that young men with eating disorders show the same clinical features as young women; however, men show less of a preoccupation with food or a drive for thinness, and place more emphasis on athletic appearance or

attractiveness as the rationale for their disturbed eating behaviour (Andersen, 1984; Burns & Crisp, 1985; Fichter, Daser, & Postpischil, 1985; Geist, Heinmaa, Katzman, & Stephens, 1999; Margo, 1987). Consequently, males are found to be more hyperactive and obsessively involved in sports than females (Crisp & Burns, 1983; Crisp, Burns, & Bhat, 1986; Fichter et al., 1985; Margo, 1987).

However, some males who develop eating disorders are also more likely to have experienced generally higher premorbid obesity than have females (Andersen & Mickalide, 1983; Carlat & Camargo, 1991; Crisp et al., 1986; Herzog, Norman, Gordon, & Pepose, 1984; Margo, 1987). The common research finding that those who diet weigh relatively more than those who do not is consistent with this view. Andersen (1995) concludes, “the general principle holds that most women who diet *feel* fat, while slightly more than half of the males who diet *are* medically obese to some degree” (p. 178).

One clinical difference suggested in a number of studies is the tendency for the onset of eating disorders to occur later in men than in women (Carlat & Camargo, 1991; Sharp et al., 1994). In addition to puberty being the highest risk period for the onset of eating disorders, research has consistently documented that puberty normally begins and ends 1.5 to 2 years later in boys than in girls as well (Carlat & Camargo, 1991; Offer, Schonert-Reichl, & Boxer, 1996). Furthermore, the hormonal changes caused by a presenting eating disorder have some physiological consequences in males which effectively delay or reverse puberty (Braun, Sunday, Huang, & Halmi, 1999). Crisp and Toms (cited in Sterling & Segal, 1985) state that, “because males reach this developmental period at a later age, they are perhaps better protected from the stresses of pubescence and less likely to be symptomatic” (p. 569).

However, biological factors may also insulate males from processes that act in developing eating disorders. As Steiger (1989) reports, males' generally lower percentage of body fat may reduce their susceptibility to the development of pathological preoccupations with fat and weight. Furthermore, "since males show a lower incidence of major affective disorders, especially among the age group 'at-risk' for eating disorders, one might speculate that reduced risk of depression has a role to play in accounting for the lower incidence of eating disorders in males" (Steiger, 1989, p. 422). However, in spite of the prevalence of eating disorders reported in males during adolescence, such eating disturbances can appear from a very early onset, during the prepubertal years, or in early adult life, during the 20s to late 40s, as well (Andersen et al., 1983; Vandereycken & Van den Broucke, 1984).

Also of clinical discrepancy, Carlat et al. (1991) report significantly less frequent diet pill and laxative abuse in males than in females. This occurrence corresponds to the finding that bingeing and purging appear to be somewhat more frequent in males with eating disorders than in females with the same disorders (Crisp et al., 1986). According to Braun and colleagues (1999), "this gender difference in methods of weight control among eating disorder patients may be related to the higher metabolic rate in males, which may make it easier for males to lose weight without resorting to diet pills and purgatives" (p. 422). Fichter and Daser (1987), on the other hand, noted that somatic complaints were more often found in males than in females, often citing feeling nauseated, abdominal discomfort and food making them tired as reasons for not eating.

The only phenomenological difference frequently reported is an apparently higher rate of homosexuality or gender identity disturbance in men with eating disorders

(Andersen & Mickalide, 1983; Burns & Crisp, 1985; Fichter & Daser, 1987; Fichter et al., 1985; Mitchell & Goff, 1984; Steiger, 1989). The foundation for “this heightened vulnerability appears to be the increased valuation of thinness in the gay culture rather than any intrinsic consequence of sexual orientation” (Andersen, 1999, p. 216).

Except for variance in homosexual status, studies detect relatively few differences between eating-disordered males and females. However, some research indicates that bulimic men may experience more relationship problems than do women. According to Herzog and colleagues (1984), bulimic men are less likely to be in romantic relationships than bulimic women, perhaps as a result of their interpersonal isolation and rigidity. Aside from the aforementioned, findings regarding gender differences continue to emerge less clearly.

Rationale for the Study

To date, no single factor has been isolated as the major cause of any type of eating disorder. However, in an attempt to explain the degenerative process of developing an eating disorder, it is imperative that one acknowledges modern culture as a salient influence. In fact, it would appear that certain features of contemporary Western culture are almost prerequisites for eating disorders (Pinel, Assanand, & Lehman, 2000, cited in Mash & Wolfe, 2002). Personal freedom, an emphasis on instant gratification, the availability of food any time of night or day, lack of supervision and the cultural ideal of diet and exercise for weight loss are all considered to be powerful influences (Attie & Brooks-Gunn, 1995). These factors, in turn, contribute to an interminable drive for thinness and an emphasis on body image and appearance. As Pope et al. (2000) have

proposed, “society increasingly extols the low-fat look in men, and it’s likely that some men develop eating disorders in response to this pressure” (p. 130).

The issue of whether there are fewer males with eating disorders because males are less exposed to social pressures promoting thinness, or whether they have intrinsic biologic protection against eating disorders continues to be a topic of concern for many researchers (Andersen, 1999). If anything, “most of the data supports the impression that males are less exposed to dieting and have a different social learning pattern to explain the lower frequency” (Andersen, 1999, p. 218).

It would appear that most men have not been as concerned about obtaining thinness as women. Andersen (1999) suggests, “on the whole, boys and men are more concerned about shape change than weight change, although both concerns may be present” (p. 216). Between the first and fifth grades, boys socially learn to perceive themselves as fat only at weights above population norms, while women perceive themselves as fat at 10 to 12 percent under norms; after that time, there exists a continuing perception of body fatness in 70 to 80 percent of school-age girls and in about half as many boys (Andersen, 1999).

Additionally, researchers have placed considerable importance on the role of the family in considering causes of eating disorders. Minuchin, Rosman, and Baker (cited in Mash & Wolfe, 2002) have argued that alliances, conflicts or interactional patterns within a family may play a causal role in the development of eating disorders among some individuals. Accordingly, an individual’s eating disorder may be functional in that it overtly directs attention away from existing dissension in the family to the individual’s more apparent problem. As Vandereycken (1995) reported, “anorexia nervosa families

of the middle and upper social classes are known for their tendency to idealize the family picture or at least to present themselves as if nothing was wrong except for the eating disorder” (p. 222).

Brown, Cash, and Lewis (cited in Schwartz, Phares, Tantleff-Dunn, & Thompson, 1999) found that adolescents with eating disturbances have a greater history of being teased about their appearance than non-eating disturbed adolescents. Rieves and Cash (cited in Schwartz et al., 1999) reported that mothers and fathers were frequent perpetrators of this appearance-related feedback. In such an instance, feedback was often associated with poorer body image for women. For men, however, overall psychological functioning appeared to be affected in a negative manner.

More often than not, remarks about weight and appearance are not perceived as trivial comments but rather experienced as personalized attacks. In response, individuals will often begin to inflict hurt or shame onto the people they initially perceived as attacking them. Such harm, according to Stoller (cited in Halperin, 1996), is normally administered via restrictive dieting or other unhealthy eating behaviours. It seems “what they experienced in a terrifying manner becomes through role reversal the scenario to master the stress and anxiety evoked in the initial traumatic situation” (p. 164). Sadly, the effects of this type of feedback are longstanding, often staying with an individual well into adulthood.

Purpose Statement

The purpose of this study was to describe, in an attempt to understand, the lived experiences of two adult males who had been medically diagnosed with and treated, or were presently being treated, for an eating disorder. A study of the varied influences that rendered these males “at-risk” ultimately improved our understanding of the processes specific in the development of the disorder.

Research Question

What is the nature of the experiences of males who have an eating disorder?

Definition of Terms

Diagnosis of an eating disorder in males is made by the same criteria as those of females (Andersen, 1999). As outlined by the American Psychiatric Association (2000), the following represents the criteria for anorexia nervosa and bulimia as stated in the fourth edition of the Diagnostic and Statistic Manual (DSM-IV):

Anorexia Nervosa (AN):

- A. Refusal to maintain body weight at or above a minimally normal weight for age and height.
- B. Intense fear of gaining weight or becoming fat, even though underweight.
- C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

- D. In postmenarcheal females, amenorrhea – that is, the absence of at least three consecutive menstrual cycles. In the case of males, Fichter and Daser (1987) identified a loss of sexual interest and lack of potency.

Specify type:

Restricting Type: During the current episode of anorexia nervosa, the person has not regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: During the current episode of anorexia nervosa, the person has regularly engaged in binge-eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

(p. 589)

Bulimia Nervosa (BN):

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
1. eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances
 2. a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

- B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induce vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for three months.
- D. Self-evaluation is unduly influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify type:

Purging Type: During the current episode of bulimia nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Nonpurging Type: During the current episode of bulimia nervosa, the person has used other inappropriate compensatory behaviours, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

(p. 594)

CHAPTER TWO

Review of the Literature

There has been an increasing interest in the role that the family and cultural pressures to be thin play in the development of eating disorders in females. Considerable research, almost entirely quantitative in nature, has examined this influential relationship and continues to garner much attention globally by researchers. The explicit intent of this study, however, was to detail the lived experiences of two adult males who had been afflicted with, or were currently suffering from, disordered eating. Conjointly, a progressive need existed to familiarize readers with the familial and sociocultural influences on ideal body size and associated eating and dieting patterns in males.

Ultimately, an understanding of these salient influences on the aetiology of disordered eating in males will contribute to extant research, albeit scarce, and provide important implications for counselling psychologists and educators. Aside from the need for males' perceptions of their experience to be revealed, a greater need exists for this information to be made available to those individuals who interact with and assist them on a daily basis in a variety of settings. Moreover, the information attained may have possible future implications for counselling practice, research and theory, specifically in programs for treatment and prevention of eating disorders in the male subculture.

Sociocultural Influences

From the available findings, it appears that men and women with eating disorders display far more similarities than differences. As such, findings based solely upon females may be generalized to include males as well (Crisp, Burns, & Bhat, 1986; Fichter & Daser, 1987; Steiger, 1989). Although societal pressures to be thin are exerted more

strongly and consistently on women than on men, “vague ‘sociocultural factors’ are often alluded to as etiologic in the development of eating disorders in the male” (Schneider & Agras, 1987, cited in Mickalide, 1990, p. 30).

The media continue to be a prominent influence in the development of eating disorders. But though there is clearly less general sociocultural reinforcement for slimness and dieting for males than for females, young men are still “confronted daily with a definition of manhood which is distorted, dysfunctional, and potentially destructive” (Kearney-Cooke & Steichen-Asch, 1990, p. 63). If anything, recent studies demonstrating the increasing muscularity of male action toys (Pope, Olivardia, Gruber, & Borowiecki, 1999) and *Playgirl* centrefold men (Leit, Pope, & Gray, 2001) have suggested that modern society praises an increasingly muscular male body ideal (Andersen, 1995; Pope, Phillips, & Olivardia, 2000). Although the cause of this trend is not certain, Leit et al. (2001) outline the possible influence of coequality in relationships. According to the authors, “women have rapidly achieved parity with men in many aspects of life, including even military roles, leaving men with only their bodies as a distinguishing source of masculinity” (p. 92). Unfortunately, because men are not to worry about and comment on their physical appearance, few would ever acknowledge, however true, that their preoccupation with their body image is the result of threatened masculinity (Pope et al., 2000).

In fact, recent work has revealed several disturbing trends, resulting in an increased interest in male body image, eating and exercise patterns. For example, a condition called muscle dysmorphia has been described, in which muscular men perceive themselves as thin and underdeveloped (Andersen, 1999; Pope, Gruber, Choi, Olivardia,

& Phillips, 1997). The distorted body perceptions of males with muscle dysmorphia are strikingly analogous to those of women with anorexia nervosa (Pope et al., 2000). In fact, some people have commonly referred to the condition as “bigorexia nervosa” or “reverse anorexia.” In a recent study conducted by Pope et al. (2000), the authors identified males with muscle dysmorphia to display levels of pathology similar to men afflicted with eating disorders. In particular, males from these two groups “shared a need to exercise every day, shame about their body image, feelings of being too fat, dislike of their bodies, and often, lifetime histories of anxiety and depression” (p. 11). However, unlike those males with anorexia nervosa, males with body dysmorphia possess a *primary* focus on exercise with a secondary focus on dieting. This disorder is commonly associated with impaired self-esteem; symptoms of mood, anxiety and eating disorders; and a high prevalence of anabolic steroid abuse. According to Drenowski, Kurth, and Krahn (1995), anabolic steroids, which are taken in an effort to increase muscular build and weight gain, may be used by .6% of adolescent boys, a rate comparable to that of anorexia nervosa among adolescent girls.

Analysis of magazines read by young women (age 18 to 24) compared with those read by men of the same age shows that young women are exposed to 10 times as many advertisements and articles extolling thinness (Andersen, Cohn, & Holbrook, 2000; DiDomenico & Andersen, 1988). Those magazines targeted primarily to women include a greater number of articles and advertisements aimed at weight reduction while those targeted at men contain more shape articles emphasizing activity, movement and physical prowess. Although it has been suggested that exposure to muscular male figures in advertisements produces measurable body dissatisfaction in men (Leit, Gray, & Pope,

2002), such dissatisfaction is primarily related to male musculature, rather than body fat. This finding remains consistent with previous evidence that identifies muscularity to be more important than body fat in men's overall body satisfaction. As reported by Furnham and Calnan (1998), "this difference between the desire for shape change, in males, as opposed to weight loss through dieting, in females, may also be a function of the different male and female ideals, since the male ideal is a V-shaped figure while the female ideal is being extremely thin" (p. 59).

Furthermore, concerns about physical attractiveness have also been portrayed on television. Gerbner and colleagues' (cited in Mickalide, 1990) analysis of a week's sample of dramatic programs revealed that fewer than 6% of all males and 2% of all females were obese, a significant under-representation of obesity in the general population. The prevalence of body dissatisfaction among males is also attributable to the increased exposure to the "supermale" images portrayed on daily television and in modern cinema (Pope et al., 2000). Unfortunately, these leaner and more muscular images have misled many men into thinking that such an image is actually attainable. Andersen and Holman (1997) offer the explanation that "while the media have been blamed for the culture of thinness, they more likely mirror society and participate, in a complex circular fashion, in setting social norms" (p. 392). As suggested by Smolak, Levine, and Schermer (1998), preventive and early intervention strategies need to be implemented if one is to attempt to understand the destructive nature of individually internalizing these societal values promoted in the media.

Emphasis on weight reduction begins early in the socialization process, particularly among females. Rosen and Gross (cited in Mickalide, 1990) identified girls

were four times more likely than boys to be attempting to reduce weight through exercise and caloric intake reduction. In contrast, boys were three times more likely than girls to try to gain weight, conforming to stereotypical ideals favouring slender women and athletic, muscular men. If anything, “girls expressing the greatest body dissatisfaction were those who believed they were overweight, whereas the most dissatisfied boys were those who believed they were underweight” (Page & Allen, 1995, cited in Cohane & Pope, 2001, p. 374).

In their recent study of adolescent males, Keel, Klump, Leon, and Fulkerson (1998) found that disordered eating existed among some males irrespective of their apparent low body weight. This finding suggests that males afflicted with the disorder may be difficult to detect, and subsequently treat, because they may not necessarily appear to be underweight. Nevertheless, many males express dissatisfaction as well, some preferring a thinner ideal image while others, a heavier one. These body image problems are often associated with impaired self-concept and low self-esteem. In general, body satisfaction among boys is positively correlated with self-esteem (Cohane & Pope, 2001). “The self-esteem of overweight boys,” according to O’Dea and Abraham (1999), “is lower than that of their normal-weight counterparts, and this may make them more likely to develop disordered eating behaviours” (p. 273).

However, Polivy and Herman (cited in Drewnowski & Yee, 1987) identify that dieting itself may be the chief risk factor for developing eating disorders. Whereas women usually dieted to lose weight, men usually exercised. Drewnowski and Yee (1987) concluded, “it may be that the key difference between the sexes with respect to the aetiology of eating disorders is not dissatisfaction with body weight but rather actual

behaviours related to diet and exercise” (p. 633). Unlike females, males may set more realistic weight goals for themselves and may have a less distorted self-image, an indication that they may be less compulsive about dieting (Schneider & Agras, 1987). As reported by Carlat and Camargo (1991), most studies comparing dieting behaviour in males and females have found that about one-half as many men diet as women. The authors ratiocinate, “to the extent that dieting acts as both a risk factor and a precipitant of developing an eating disorder, males are relatively protected from the disorder by their more positive body image and lower prevalence of dieting” (p. 836). As Siever (cited in Braun, Sunday, Huang, & Halmi, 1999) suggests, additional risk factors, including participation in occupations or hobbies in which weight is important for good performance, may need to be present to understand what induces some males to diet or to focus attention on their bodies.

The supposition that eating disorders were more prevalent among certain subgroups of individuals, particularly those of higher socioeconomic status, went undisputed for several decades. However, recent studies have found anorexia nervosa and bulimia to be distributed equally across socioeconomic classes, undermining the notion that eating disorders occur only in the middle and upper classes (Granther, Post, & Zaynor, 1985; Herzog, Norman, Gordon, & Pepose, 1984). Pope and colleagues (cited in Mickalide, 1990), for example, surprisingly identified eating disorders to be more common among lower social classes. Ogden and Thomas (1999) provided support for this finding when they reported that lower class subjects have a more negative stereotype of obesity and valuing physical appearance than did higher-class subjects. As Mickalide (1990) suggests, “the initial perception of eating disorders as an upper class phenomenon

may have been due to better access to medical care, and hence diagnosis, among wealthier populations” (p. 35). Similarly, Doyle and Bryant-Waugh (2000) account for the over-representation of certain social classes by suggesting that middle-to-upper class families may be better at making use of facilities readily available to them. However, it remains uncertain as to whether this finding represents a social class bias or an important risk factor. Certainly it is a finding of interest that requires further investigation. In spite of this historical tendency, it now appears that eating disorders may not differentiate on the basis of social class. If anything, “it has been suggested that it is not social class *per se* but the pressure to achieve which may be associated with eating problems” (Doyle & Bryant-Waugh, 2000, p. 54).

Until recently, eating disorders have been thought of as being highly culture-specific. Although Dolan (cited in Mash & Wolfe, 2002) recently reported the incidence of anorexia to be considerably lower in North America among immigrant and minority populations than in the majority population, this finding assists in refuting the earlier notion that *only* Caucasians equate extreme thinness with beauty. For many years, no identified cases of anorexia and bulimia in minorities appeared in the literature. Although a wealth of research on the cultural meaning of body image in relation to gender has been presented over the last several years, the influence of race and ethnicity is only beginning to be explored.

Traditional studies have reported higher rates of eating-related problems in females, in Caucasians and in Western cultures. However, these global findings are far from unequivocal. According to Barry and Grilo (2002), recent studies have reported that adolescents and adults of minority descent are affected substantially by eating-related

problems. Furthermore, they continue, the prevalence of some eating problems, including bingeing, may be comparable to those observed in Caucasians. Yates (cited in Mash & Wolfe, 2002) reported that minority adolescents are particularly at risk for developing eating disorders because of their motivation to be accepted into the dominant white culture. In fact, according to Wilfley and Rodin (1995), “eating disorder traits, including excessive restraint, fear of fatness, and dissatisfaction with body image, have been shown to be related to non-Caucasian individuals’ degree of Westernization and assimilation into the Caucasian culture” (p. 81).

Although male to female ratios of eating disorders in minorities have not been established to date, interesting cross-cultural differences are particularly noticeable in college populations. In spite of finding low rates of bulimia among Caucasian and Black males in their college population, Gray and colleagues (cited in Mickalide, 1990) reported a higher frequency of bingeing, fasting and dieting among Black males, compared to their Caucasian counterpart. Of even greater interest, Black males were also significantly less likely to consider themselves overweight at the time of the study. Other reputable studies, in contrast, have indicated that European American men tend to be significantly more dissatisfied with their body weight than Black men (Gray, Ford, & Kelly, 1987; Harris, Walters, & Waschull, 1991). Nonetheless, these findings warrant further investigation.

In both males and females the consideration to lose weight tends to be concentrated among specific subgroups. Athletes, for example, are considered at high risk for diagnosable eating disorders. In their analysis of the athlete-eating disorder literature, Hausenblas and Carron (cited in Petrie & Rogers, 2001) found that male

athletes scored higher on bulimic, anorexic and drive for thinness indices than non-athletes. Andersen (1999) reported that the direction of weight change desired by males is often determined by the nature of the sport. Whereas a high percentage of males in gymnastics, swimming and football are vulnerable to developing eating disorders, males who wrestle, on the other hand, “correspond roughly to women who undertake ballet training; both groups show a disproportionate increase in eating disorders, seven to ten times normal” (Andersen, 1995, p. 178). In addition to anaerobic activities, in particular bodybuilding and weightlifting, early research with runners has suggested a parallel between excessive engagement in these activities and anorexia nervosa (Boroughs & Thompson, 2002). According to Sungot-Borgen (cited in Patrick, 2002), “the most common eating disorder in athletes involves exercise bulimia – using exercise as a form of weight reduction along with the use of laxatives, emetics, diuretics, and stimulants” (p. 184).

To date, it remains indefinite as to whether males with aberrant eating patterns seek out particular professions or whether vocational choices give rise to their eating-disordered behaviours. However, it appears that male jockeys, swimmers, models and dancers are more vulnerable to eating disorders because their professions clearly necessitate weight restriction (Mickalide, 1990).

The sociocultural environment also varies between the sexes in regard to differential reinforcements for dieting and weight loss. Not only do men and women perceive fatness differently and value different shape ideals, they are also more apt to change in their perception of slimness if they experience a gay or lesbian sexual orientation. According to Herzog, Bradburn, and Newman (1990), “the clinical picture of

anorexia nervosa and bulimia nervosa appears to differ for men and women in this domain, with more eating-disordered men exhibiting gender dysphoria and/or a homosexual orientation than their female counterparts” (p. 40).

According to Hepp and Milos (2002), among the studies that have been conducted in the last 20 years concerning male eating disorders, most have emphasized the role of sexual orientation for the development of these disorders. Homosexual men seem to be at higher risk for developing body dissatisfaction and have an increased vulnerability to eating disturbances (Andersen, 1999; Andersen et al., 2000; Carlat & Camargo, 1991; Siever, 1994; Silberstein, Mishkind, Striegel-Moore, Timko, & Rodin, 1989; Williamson, 1999). According to French et al. (1996), homosexual males are “less likely to perceive themselves to be the right weight, or to report a positive body image, and are more likely to binge eat, fear not being able to control their eating, frequently diet, or engage in purging behaviours compared to heterosexual males” (p. 124). Not only does research suggest that homosexual men may present for treatment of eating disorders proportionately more than heterosexual men (Herzog et al., 1984), it has been also reported that physical appearance is of heightened importance in the gay male subculture: homosexual men rated the role of physical attractiveness as more important to their sense of self than did the heterosexual men (Silberstein et al., 1989). As reported by Williamson (1999), gay men, like heterosexual women, may believe in the centrality of appearance in attracting potential partners. Although Siever (1994) identified men as tending to evaluate potential romantic partners on the basis of physical appearance to a greater extent than women, he did conclude that both gay men and heterosexual women place particular emphasis on their body image to attract male partners. Additionally,

Herzog et al. (1990) reported that significantly more male anorexics display anxiety, aversion and conflicted homosexuality with regard to sexual activities and relationships than among male bulimics and females.

Although the paucity of literature addressing sexuality in eating-disordered males parallels their low prevalence rates, the relatively few findings available “indicate that psychosexual and gender identity conflicts, as well as sociocultural pressures for homosexuals, may contribute to the development of eating disorders in men” (Herzog et al., 1990, p. 48).

Familial Influences

Families of the male anorexic have similar patterns with those found in females. In addition to being overly-sensitive, prone to feelings of guilt and inadequacy and driven toward overcompensation (Sterling & Segal, 1985), adolescents with anorexia are clinically described as being obsessive and rigid, preferring the familiar, having a high need for approval and showing poor adaptability to change (Casper, Hedeker, & McClough, 1992). Those individuals, specifically, tend to be hypersensitive to rejection, frequently citing ambiguity or complexity to be extremely confusing to them (Halperin, 1996). The restraint of negative, but not positive, emotions is also commonly reported. It is stated that in addition to having very low self-esteem, these afflicted individuals view the expression of negative emotions such as anxiety, sadness and anger as a sign of weakness or imperfection that they cannot allow. As Lask (2000) reports, “the perfectionist personality of those with anorexia nervosa could be an important contributing factor in the persistent restraint required to maintain a very low weight” (p. 66).

However, another possible interpretation exists. As reported by Woodside et al. (2002), mothers, and to a lesser extent fathers, of individuals with anorexia nervosa were observed as exuding greater perfectionism and higher levels of eating disordered-type attitudes and behaviours. If anything, one must not ignore the conceivability that “perfectionism is an environmentally transmitted trait and that parental perfectionism ‘flows down’ to the offspring generation via an environmental pathway such as modeling” (Woodside et al., 2002, p. 297).

Bruch (cited in Lask, 2000) suggests that self-starvation among persons with anorexia is the result of a continual struggle for autonomy, competence, control and self-respect. She links this struggle most closely to parental failure to recognize and confirm their child’s emerging needs. Gilligan (cited in Lask, 2000) conceptualizes that female development is centred on making and sustaining relationships, while independence and self-direction is encouraged in males. Cognitive-behavioural therapy proposes that “...anorexia nervosa develops as a way of coping with adverse experiences often associated with developmental transitions and distressing life events...” and that “...food restriction and rituals of food avoidance become entrenched habit patterns, independent of the events or issues that provoked them” (Kliefeld, Wagner, & Halmi, 1996, p. 715).

The dysfunctional family has long been theorized as having a role in the development of eating disorders. In a review of studies with families of disordered individuals, Strober and Humphrey (cited in Wertheim et al., 1992) found some evidence that the families were “characterized by enmeshment, poor conflict resolution, emotional involvement or detachment, and a lack of affection and empathy” (p. 152). Additionally, Palazzoli (cited in Bryant-Waugh & Lask, 1995) reported that in those instances where an

individual's eating disorder was perceived as threatening to the family structure, rigidity and enmeshment were salient. This type of family stresses the values of cohesion, loyalty and self-sacrifice, which in turn, seems to exacerbate the anorexia.

Conversely, the family patterns for bulimic males have been described as unsupportive, chaotic and prone to secrecy (Carlat & Camargo, 1991). Vandereycken (1995) revealed that bulimics view their families as conflicted, badly organized, noncohesive and lacking in nurturance and caring. Although he found parents, in general, to report similar perceptions, they often tend to be less extreme in their reports than their eating disordered child.

Minuchin (cited in Bryant-Waugh & Lask, 1995), on the other hand, has acknowledged that there must be a precursor of physiological vulnerability before the eating disorder can develop. His description of the "anorexic" family as over-involved, rigid, over-protective and avoiding conflict appears to confirm other research findings. Vandereycken (1995), for example, reported anorexic families to show "more rigidity in their family organization, have less clear interpersonal boundaries, and tend to avoid open discussions of disagreements between parents and children" (p. 220). Because individuality is strongly discouraged, disordered individuals will often dissociate from their unyielding family in an attempt to establish some sense of control over their own life, which they often think they can do by rigidly controlling their diet and body image.

These hypotheses have also actually been contradicted with empirical evidence. Rosen and associates (cited in Wertheim et al., 1992) suggested, "dieting and bingeing may not be the result of poor psychological adjustment, rather eating disturbances may lead to the observed psychosocial difficulties" (p. 159). In other words, the family may

not actually be as overprotective and lacking in cohesiveness as initially viewed, but rather the child mistakenly perceives them in this way. According to Heron and Leheup (cited in Casper & Troiani, 2001), patients with restricting anorexia nervosa report to “feel happy” with their families, while parents of patients with restricting anorexia nervosa indicate less conflict, more cohesiveness, and better relationships than parents of bulimic anorexia nervosa patients (Strober, Salkin, Burroughs, & Morrell, 1982). These findings extend and confirm work by other researchers as well. Vandereycken (1995), for example, revealed anorexics to perceive their families as stable, nonconflictual, cohesive and not lacking in nurturance. Ordman and Kirschenbaum (1986) and Strober, Morrell, Burroughs, Salkin, and Jacobs (1985) have all reported higher levels of conflictual interactions among adolescents with the bulimic type of anorexia nervosa and greater marital discord among parents compared with families of restricting anorexic patients. Because of the inability to disentangle cause from effect, these interpretations are offered as tentative findings.

Recent advances in the field of emotion research suggest that shame may serve as an intercessor in the link between the family and bulimic psychopathology. Both shame-proneness – an oversensitivity to experience shame in social situations – and internalized shame – internal attributions about the self resulting from chronic exposure to shameful situations over time – have been shown to be associated with bulimia (Murray, Waller, & Legg, 2000). According to Murray et al. (2000), “internalized shame may result from chronic exposure to a ‘shame-bound’ family environment” (p. 85), one that is often characterized by insufficient parental care and relatively high levels of paternal control and intrusion.

Although Kog and Vandereyecken (cited in Bryant-Waugh & Lask, 1995) concluded there is no typical “anorexia nervosa family”, they did, however, confirm empirical evidence that families with anorexic children do display dysfunctional interaction and communication. Lask (2000) reasons: “For the moment we can be confident that family dysfunction, possibly also including abnormal eating attitudes and behaviour, can perpetuate eating disorders, but we have little evidence that it can predispose to, or precipitate them” (p. 71).

Although many similarities exist between males and females afflicted with eating disorders, some important differences have also been detected. For example, “males are more likely than females to have companion disorders of substance abuse, including alcohol abuse, mood disorders, or antisocial personality traits, although the majority of anorexic males have self-critical, anxious, or obsessive-compulsive personality features, while bulimic males may be more dramatic or narcissistic” (Andersen, 1999, pp. 217-218). This finding is congruent with that of Bramon-Bosch, Troop, and Treasure (2000) who reported that males, in comparison to females, have a stronger psychiatric comorbidity and exhibit more frequent suicidal behaviour. However, these discrepancies extend to families as well. Crisp and Toms (cited in Steiger, 1989) have contended that the families of male anorexics are more pathological than those of females. On average, “male and female anorexics’ families frequently exhibit histories of affective disorder and other forms of psychopathology” whereas “in the families of bulimics (male and female), incidences of substance abuse and affective disorders are elevated, and there is more evidence of disorganization and incohesiveness” (Steiger, 1989, p. 421).

Furthermore, trends in the families of anorexic males suggest the overidentification of the anorexic son with his mother, and the mothers as often overcontrolling (Fichter & Daser, 1987; Sterling & Segal, 1985). Although Bemis (1978) notes maternal ambivalence found with female anorexics, with males more overly close and conflictual patterns were indicated with boundaries more likely to be permeable. Steiger (1989) further indicates a lack of involvement in the family, and with the son, on the father's part. This finding is consistent with that of Sterling and Segal (1985) who reported that, in a sizable number of cases, the father and son relationship was overtly conflictual and described as being domineering, controlling and rigid. In marked contrast to reports of fathers of female anorexics as passive and not contributing in a major way to family functioning (Rowland, 1970); the fathers of anorexic males seems to play a major role in this regard.

In the available literature on families of eating disordered patients, parenting styles have been neglected to a great extent. From a clinical viewpoint, Vandereycken (1995) identified "the lack of adequate joint parental authority" as a commonly observed feature where "parents have problems finding a balance between adequate (i.e., rational and flexible) control of their child and the age-appropriate autonomy they give to the child" (p. 220). Although at first glance these problems appear to be related to the parents' failure to reach a consensus concerning child-rearing issues, in many cases, these shortcomings in conjoint parenting are probably the result of more prominent problems in the marital relationship (Vandereycken, 1995).

In examining the personality profile of eating disordered men, Kearney-Cooke and Steichen-Asch (1990) speculated that

[eating-disordered] men had a parent or parents who discouraged independence and possibly set up barriers to keep their child from gaining autonomy. They may have been overprotective and may have made few demands for self-responsibility; they may have rewarded their sons for remaining more dependent. As a result, these boys failed to develop a cohesive sense of self separate from their parents. Their intense dependence on others may have robbed them of the opportunity to do things for themselves, to go autonomous may have deprived them of the experiences needed to develop attributes that would distinguish them as individuals. Thus, in a culture that emphasizes thinness, having the perfect lean body could provide an opportunity for these men to attain an identity. (p. 67)

Sensitive issues such as parental preference and sibling rivalry have been also addressed in recent years. Parental preference, as described by Halperin (1996), relates to competition within the family. For the anorexic, preference is not only associated with weight but also to status and power in the family. Bieber (cited in Halperin, 1996) sees “parental preference as being a transference identification based on appearance, accomplishment or the child as their younger self” (p. 165). An anorexic’s behavior, he continues, often mimics a preferred sibling style. However, because research in this area continues to be rather fragmentary and scarce, these findings are tentative at best.

In response to the findings presented here, Kearney-Cooke and Steichen-Asch (1990) offer the following profile of a male who is susceptible to developing an eating disorder

...this man appears to lack a sense of autonomy, identity, and control over his life. He seems to exist as an extension of others and to do things because he must please others in order to survive emotionally. We speculate that he came from an environment which is unable to validate his strivings for independence, a situation which leaves him at risk for symptom formation later in life. He has a history of experiences around his body (such as being teased about his body shape) which leaves him vulnerable about his body image. He tends to identify with his mother rather than with his father, a pattern which leaves his masculine identity in question and establishes a repulsion of “fat” which he associates with femininity. He also lives in culture which emphasizes thinness and fitness, and exaggerates the importance of body image as a result. (p. 68)

More recent studies have reported that childhood physical or sexual abuse could be underlying causes of eating disorders among some individuals. As reported by Neumark-Sztainer, Story, Hannan, Beuhring, and Resnick (2000), youth who have experienced either physical or sexual abuse are at increased risk for disordered eating behaviours. The authors tentatively suggested that “among girls it is the experience of abuse, not necessarily the sexual component of abuse that is associated with disordered eating” while “among boys the association of sexual abuse with disordered eating was considerably stronger than that between physical abuse and disordered eating” (p. 255). Consequently, males will tend to learn to suppress their emotional expression, feel shame at the inadequacy of their body regardless of what they actually look like and choose instead to use their body to express their unconscious feelings, albeit aggressive, sexual or other (Andersen et al., 2000).

As suggested by Kinzl and Biebel (cited in Kinzl, Mangweth, Traweger, & Biebl, 1997), “adverse childhood experiences may lead to ego weakness, deficient self-esteem, and unstable communication with reduced frustration tolerance” (p. 136). As such, this may result in inadequate coping mechanisms, such as bingeing, when the subject is faced with stressful life events. This finding, however, is not without support. According to Wonderlich (cited in Mash & Wolfe, 2002), sexually abused children report many of the early risk signs of eating disorders, such as higher levels of weight dissatisfaction and purging and dieting behaviour. Fairburn (1994), on the other hand, states such events are not uncommon in the background of individuals with eating disorders or in those with other psychiatric disorders. Although no evidence exists to demonstrate that either sexual abuse or other stressful life events are specific predisposing factors for eating disorders,

they may contribute to the onset of the disorder by combining with dieting to precipitate the disorder in a vulnerable individual.

CHAPTER THREE

Research Design and Methodology

The purpose of this study was to elucidate the lived experiences of two males afflicted with disordered eating. Of additional interest, however, was the examination of familial and sociocultural influences on disordered eating behaviours in males. Consequently, the methodology employed in this qualitative study facilitated the exploration of participants' narratives in relation to these external domains. Presented in this chapter are the processes and procedures outlining how participants were selected and how data were gathered, analyzed and subsequently delineated. Also identified in this chapter are the measures that were taken to protect participant confidentiality and anonymity throughout the research process.

An Appropriate Qualitative Paradigm

Even within well-structured parameters, qualitative research is rather loosely defined. According to Merriam and Muhamad (2000), qualitative research is descriptive and inductive in nature, focusing on uncovering meaning from the perspective of participants. In attempting to understand the meaning associated with a specific phenomenon, "qualitative researchers build toward theory from observations and intuitive understandings gleaned from being in the field" (Merriam, 2002). Meaning, however, "is not discovered but constructed. Meaning does not inhere in the object, merely waiting for someone to come upon it.... Meanings are constructed by human beings as they engage with world they are interpreting" (Crotty, 1998, pp. 42-43, cited in Merriam, 2002, p. 37).

Creswell (1998), on the other hand, described qualitative research as being an “inquiry process of understanding based on distinct methodological traditions of inquiry that explores a social or human problem” (p. 15). More importantly, qualitative researchers assemble complex, holistic pictures, analyze words, report detailed views of informants and conduct studies in natural settings (Creswell, 1998). This recent description is seemingly congruent with that of Denzin and Lincoln (1994), who reported that qualitative researchers routinely “study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them” (p. 2).

As Merriam (2002) posits, “the key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals in interaction with their world” (p. 3). However, the informant’s world, or social reality, is not relatively constant across time or settings. Rather, multiple constructions and interpretations of reality exist that are both highly personal and continuously in flux. Qualitative researchers, thereby, are interested in understanding what those interpretations are at a particular point in time and in a particular context. As Patton (1985, p. 1, cited in Merriam, 2002) explains

[qualitative research] is an effort to understand situations in their uniqueness as part of a particular context and the interactions there. This understanding is an end in itself, so that it is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting – what it means for participants to be in that setting, what their lives are like, what’s going on for them, what their meanings are, what the world looks like in that particular setting.... The analysis strives for depth of understanding. (p. 5)

In the pursuit of subjective truths, Bogdan and Biklen (1998) identify the role of *participant perspectives* in naturalistic inquiry. Central to this definition of inquiry is the attempt to present, through natural language and as closely as possible, everyday episodes

documenting how people feel, what they know and what their concerns, beliefs and understandings are (Wolf & Tymitz, 1976-1977, cited in Guba and Lincoln, 1981). Through this inductive process, the informant's personal experiences, stories and interactions with their social world, and the meaning associated with them, becomes the focus of inquiry.

The Narrative Approach

*“Stories have the power to direct and change our lives”
Nel Noddings (1991, p. 157)*

Given the variety of qualitative research designs, “narratives have become a widespread research method” (Jovchelovitch & Bauer, 2000, p. 57) for understanding how human beings make sense of their world. The main claim for the use of narrative in qualitative research is that humans lead storied lives through actively engaging in the process of storytelling. Infinite in variety, narratives are frequently employed to construct explanations for individual experience and way of life. If anything, “there seems to be in all forms of human life a need to tell; story-telling is an elementary form of human communication and...involves intentional states that alleviate, or at least make familiar, events and feelings that confront ordinary everyday life” (Jovchelovitch & Bauer, 2000, p. 58).

As these people lead storied lives and tell stories of those lives, “narrative researchers, describe such lives, collect and tell stories of them, and write narratives of experience (Connelly & Clandinin, 1990, p. 2). Elbow (cited in Connelly & Clandinin, 1990) characterized this cooperative and collaborative relationship as the *believing game*, “a way of knowing that involves a process of self-insertion in the other's story as a way of coming to know the other's story and as giving the other voice” (p. 4). Britzman (cited

in Connelly et al., 1990) highlighted the necessity of voice in establishing this collaborative relationship:

Voice is meaning that resides in the individual and enables that individual to participate in a community....The struggle for voice begins when a person attempts to communicate meaning to someone else. Finding the words, speaking for oneself, and feeling heard by others are all a part of this process....Voice suggests relationships: the individual's relationship to the meaning of her/his experience and hence, to language, and the individual's relationship to the other, since understanding is a social process. (p. 4)

Similarly, Bruner (1990) explained that individuals learn to make sense of their lives only when they transpose their life experiences into narrative formats. Gee (cited in Muller, 1999) explicated it is only through the telling and hearing of stories will people come to understand their own experience as well as that of others. "Narrative structures," in other words, "provide a format into which experienced events can be cast in the attempt to make them comprehensible, memorable, and shareable" (Olson, 1990, pp. 100-101, cited in Carter, 1993, p. 7).

According to Merriam (2002), "the key to this type of qualitative research is the use of stories as data, and more specifically, first-person accounts of experience told in story form" (p. 9). The use of narrative methodology results in unique and personal data that typically takes the perspective of the teller, rather than that of the society (Manning & Cullum-Swan, 1994). Context is of considerable importance in narrative inquiry for "if one defines narrative as a story with a beginning, middle, and end that reveals someone's experiences, narratives may take many forms, are told in many settings, before many audiences, and with various degrees of connection to actual events or persons" (Manning & Cullum-Swan, 1994, p. 465).

Narratives, in its simplest form, “provide the frames that make it possible for us to interpret our experience, and these acts of interpretation are achievements that we take an active part in” (White, 1995, p. 15). As Polkinghorne (1988) explained:

The purpose of descriptive narrative research is to produce an accurate description of the interpretive narrative accounts individuals or groups use to make sequences of events in their lives or organizations meaningful. This research produces a document describing the narrative held in or below awareness that make up the interpretive schemes a people or community uses to establish the significance of past events and to anticipate the consequences of possible future actions. The research does not construct a new narrative; it merely reports already existing ones. (pp. 161-162)

Utilizing a narrative approach requires us, as researchers, to retrieve interpretive storied accounts individuals have around consequential events. As Wolin and Wolin (1993) stated:

Our lives are a story. There are as many stories as there are lives, and each of our stories is many stories. As authors, we are free to script and cast ourselves as we choose. Out of our complicated and varied experiences, we each select the events that have meaning for us and interpret them to fit our inner picture of who we are. Then we arrange the details in a plot that defines us – our problems, our strengths and our possibilities. In turn, the story we write exercises a powerful influence on how we feel and behave. As we construct our story, it constructs us.” (p. 59)

Of greater significance, *meaning* can be derived through one’s narratives. Meaning, however, “is not at the ‘end’ of the narrative; it permeates the whole story” (Jovchelovitch & Bauer, 2000, p. 59). As Polkinghorne (1997) explained, it is through this narrative process where meaning emerges and assists the individual to “construe what they are and where they are headed” (p. 14). More importantly, Connelly and Clandinin (1990) asserted that the association between narrative and life must not be undermined for the narrative method can render life experiences, albeit individual or social, in very relevant and meaningful ways. Parry and Doan (1994) reaffirmed this

notion, having stated, “a story told by a person in his/her own words of his/her own experience does not have to plead its legitimacy in any higher court of narrative appeal, because no narrative has any greater legitimacy than the person’s own” (pp. 26-27).

Ethical Considerations

As outlined by the University of Saskatchewan Behavioural Research Ethics Board (Beh-REB), ethical guidelines for research with human subjects were strictly adhered to. A formal application was made to the University Advisory Committee on Ethics for approval (see Appendix A). Each participant was thoroughly informed of the purpose, procedures and anticipated benefits of the study, the extent and duration of their participation and how the information provided would be utilized (see Appendix B). Since the subject matter under investigation had the *tendency* to be very sensitive in nature, as researcher, I had to be continually attentive to any emotional responses that might have been elicited. In the event that issues arose during the interviews that concerned the participant(s) or myself, appropriate support, including professional counselling services, for the participant(s) were made available. As such, participants were informed that their participation was voluntary and that they could withdraw from the study at any time.

Through the utilization of pseudonyms of their choice, the necessities of preserving confidentiality and anonymity of participants were ensured. Participants were also informed that all audio tapes, transcriptions and other identifying data would be destroyed following a wait period of five years after successful completion of the study. Of paramount significance, participants were also afforded the opportunity to access the

collected information at any time for the purposes of checking for accuracy and omissions (see Appendix C).

Participant Selection

The participants for this study were selected through the process of convenience sampling, a strategy that is based on the assumption that “the persons participating in the study were chosen because they were readily available” (Mertens, 1998, p. 265).

Although this might be the least desirable sampling strategy, it is probably the most commonly used. As Gall, Borg, and Gall (1996) state:

researchers often need to select a convenience sample or face the possibility that they will be unable to do the study. Although a sample randomly drawn from a population is more desirable, it usually is better to do a study with a convenience sample than to do no study at all – assuming, of course, that the sample suits the purposes of the study. (p. 228)

To ensure appropriateness when making sampling decisions, researchers need to “(a) consider how the sample fits the research purpose and the phenomenon of interest and (b) employ a sampling strategy that is consistent with the style of inquiry” (Kuzel, 1999, pp. 44-45). Creswell (1998) suggests that certain kinds of qualitative research tend to favor certain sampling tendencies. For instance, a biographical tradition, which incorporates narrative analysis, commonly employs a convenience sampling strategy (Kuzel, 1999). Since many males usually conceal or deny having an eating disorder, the strategy of selecting cases because they were conveniently available and easy to study was, therefore, warranted.

If a convenience sample is used, the researcher must infer a population to which the results might generalize. In other words, “the researcher must acknowledge the limitations of the sample and not attempt to generalize the results beyond the given

population pool” (Mertens, 1998, p. 265). According to Gall et al. (1996), the researcher can assist the inference process by providing a careful description of the sample” (p. 228).

Participant Recruitment

Prior to the outset of the study, the researcher must establish a set of criteria that all individuals participating in the study need to possess (Goetz & LeCompte, 1984). Therefore, the initial criteria for participant selection included: (a) males who were at least 18 years of age or older; (b) males who had been medically diagnosed with and treated, or were presently being treated, for Anorexia Nervosa or Bulimia Nervosa; and (c) males who were willing to participate in the study. Through contacts with the program director at the BridgePoint Center for Eating Disorders in Mildren, Saskatchewan, two males were recruited who successfully met the eligibility criteria outlined above.

Data Collection

Within this qualitative inquiry, an unstructured interview format, employing guiding questions and probes (see Appendix D) and to a lesser extent, field notes, were utilized as the main methods of data collection. In an attempt to elude participants’ narratives, or *voices*, interviews were organized to serve the following two purposes. Firstly, as explicated by Van Maanen (1990), the interviews were “used to explore and gather narrative material that ...serve[d] as a resource for developing a richer and deeper understanding of the phenomenon” and secondly, the interviews were “used as a vehicle to develop a conversational relation with the participants about the meaning of their experience” (p. 66).

Intent on bringing meaning and its construction to the foreground, the active interview is a conversation that is guided by the interviewer and the research agenda (Holstein & Gubrium, 1995). By providing participants with the opportunity to address their story from their own perspective, the researcher is able to explore the various ways that the participant attaches meaning to the phenomena of interest. As Dexter (1970, p. 3, cited in Guba & Lincoln, 1981) stated, unstructured interviews involve “letting the interviewee introduce to a considerable extent his notions of what he regards as relevant, instead of relying upon the investigator’s notion of relevance” (p. 156). Although considered to be highly subjective and time consuming, unstructured interviews remain the ideal type of interview for examining difficult or sensitive information with respondents (Gall et al., 1996).

Encouraging respondents’ narratives are of leading importance. It is through employing an active interview guide that the interviewer is able to “engage the respondent and designate the narrative terrain” (Holstein & Gubrium, 1995, p. 76). Advisory in nature, the use of the guide may vary from one interview to the next, becoming the focus of the interview conversation on some occasions and neglected on others. As Holstein and Gubrium (1995) explained:

A rule of thumb for using an interview guide is to let the respondent’s responses determine whether particular questions are necessary or appropriate as leading frames of reference for the interview conversation. This lends a rather improvisational, yet focused, quality to the interview – precisely the image we have of the meaning-making process more generally. (p. 77)

Unlike most structured interviews that do not afford the interviewer to improvise or exercise independent judgment, this unstructured interview context allows for the interviewer to interject his or her opinion of a respondent’s answer. More importantly, in

contrast to the structured interview, this interview process adequately assesses the emotional dimension of respondents. Drawing on mutually familiar events or experiences is a means of conveying to the respondent that the interviewer is empathically sensitive to, and interested in, the ongoing conversation (Holstein & Gubrium, 1995).

Finally, the active interview serves to capitalize on the dynamic interplay between respondent and interviewer. As Holstein and Gubrium (1997) reported, “both parties to the interview are necessarily and ineluctably *active*” (p. 114). By engaging respondents in meaningful talk about their everyday worlds and by asking appropriate questions about relevant aspects of their lives and experiences, interviewers gather rich descriptions, accounts and explanations about respondents and actively construct meaning.

In an attempt to provide a literal account of what manifested throughout the interviews, field notes were actively utilized. According to Bogdan and Biklen (1998), field notes are “the written account of what the researcher hears, sees, experiences, and thinks in the course of collecting and reflecting on the data in a qualitative study” (pp. 107-108). Researchers have identified that “keeping a journal, diary, or log can be very helpful for keeping a record of insights gained, for discerning patterns of the work in progress, for reflecting on previous reflections and for making the activities of research themselves topics for study (Van Maanen, 1990, p. 73).

Gall and colleagues (1996) proposed that field notes be descriptive and reflective in nature, providing “a word-picture of the setting, people, actions, and conversations as observed” (Bogdan & Biklen, 1998, p. 121) by the researcher. In addition to assisting the researcher in closely monitoring the flow and structure of the interviews, descriptive field

notes provide valuable suggestions for follow-up questions. Conjointly, reflective field notes attempt to capture the researcher's personal account of the course of inquiry, including feelings, concerns, ideas, impressions and emerging themes or patterns. However, it is the striving for richly descriptive and accurate field notes, all the while maintaining objectivity and avoiding making judgments that continues to be of paramount significance (Glesne & Peshkin, 1992).

Through field note documentation, the identification of mere thoughts, confusions and interpretations of personal aspects of the interviews served duly purposeful. The notes did not only enable the researcher to gain analytical distance from the presenting data (Strauss & Corbin, 1990), but the formulated understandings that surfaced from them provided the direction for subsequent steps in the study. Moreover, these field notes served to lend credibility and establish the trustworthiness of the study.

Role of Researcher

The role of researcher in the qualitative paradigm is that of primary *measuring instrument* (Gall et al., 1996). Since the researcher is likely to become personally involved in the phenomenon being studied, the researcher is apt to utilize a variety of psychological processes to understand the meaning of the phenomenon as the participants in the setting experience it.

Regardless of the external circumstances and the initial perceptions, a qualitative researcher who conveys personal involvement, partiality and empathy toward respondents is more likely to foster richer, more descriptive data (Glesne & Peshkin, 1992). As Morse and Field (1995) reported, the ability of the researcher to establish

rapport, gain the participants' trust, and employ observational and open-communication skills will undeniably influence both the amount and quality of information obtained.

More importantly, it is imperative that all researcher presuppositions and known biases be aware of and accounted for throughout the research process. Peshkin (cited in Gall et al., 1996) urged "researchers to seek out their subjectivity systematically while their research is in progress, so that they can better determine how it might be shaping their inquiry and research outcomes" (p. 558). Rubin and Rubin (1995) explicated, "researchers' biases, angers, fears, and enthusiasms influence their questioning style and how they interpret what they hear" (p. 18).

Additionally, of greater relevance, the researcher's role as *learner* needs to be clearly defined. Glesne (1999) iterated the importance of the learner's perspective:

As a researcher, you are a curious student who comes to learn from and with research participants. You do not come as an expert or authority. If you are so perceived, then your respondents will not feel encouraged to be as forthcoming as they can be. As a learner, you are expected to listen; as an expert or authority, you are expected to talk. The differences between these two roles are enormous. (p. 41)

In any event, according to Creswell (1998), undertaking the role of an *active learner*, one "who can tell the story from the participants' view rather than as an 'expert' who passes judgment on participants" (p. 18) remains a paramount goal.

Data Analysis

In qualitative research, data collection and data analysis are not mutually exclusive (Merriam, 2002). According to Glesne (1999), "data analysis done simultaneously with data collection enables you to focus and shape the study as it proceeds" (p. 130). In fact, data analysis often begins with the very first data collection (Lincoln & Guba, 1985). Data analysis "involves organizing what you have seen, heard,

and read so that you can make sense of what you have learned. Working with the data, you describe, create explanations, pose hypotheses, develop theories, and link your story to other stories” (Glesne, 1999, p. 130). To do so, however, requires the unremitting categorization and synthesis of collected data and the searching for, and interpretation of, patterns and emergent themes within (Glesne & Peshkin, 1992).

Narrative Analysis

In a global sense, “story-telling comprises two dimensions: the chronological dimension, which refers to the narrative as a sequence of episodes, and the non-chronological, which involves the construction of a whole from successive events, or the configuration of a *plot*” (Jovchelovitch & Bauer, 2000, pp. 58-59). Central to the composition of a narrative structure, it is through the plot that smaller stories emerge and meaning is acquired. Jovchelovitch & Bauer (2000) accented this significance of linking narratives both in time and in meaning:

If we consider events in isolation they appear to us as simple propositions that describe independent happenings. But if they are composed into a story, the ways in which they are related allow for the meaning-production operation of the plot. It is the plot that gives coherence and meaning to the narrative, as well as providing the context in which we understand each of the events, actors, descriptions, goals, morals and relationships that usually form a story. (p. 59)

Narrative analysis “is not a form or art or a given talent. Nor is it a mere *technique*. It is a skill that requires great patience and dedication, and can be academically learned, refined, and improved” (Lieblich et al., 1998, p. 170). One aspires to seek and find meaning and solace in evocative literary and nonfictional stories. To do so, however, requires that the stories of those *silenced* and *marginalized voices* be accessible to its readers. Writing evocatively consists of celebrating the usual and the typical while *advocating* for the possible and exceptional, all the while acknowledging

the emotional and sensuous, and producing descriptive stories that evoke readers' experiences and convey lifelikeness (Ellis, 1997). In the end, such writing "concentrates on telling a personal, evocative story to provoke others' stories and adds blood and tissue to the abstract bones of theoretical discourse" (Ellis, 1997, p. 117).

To analyze narratives, "researchers treat the told stories, dialogues, or interactions as a type of text that can be interpreted and analyzed" (Ricoeur, 1984, cited in Muller, 1999, p. 228). Generally, the first step in the analysis of narratives involves a careful transcription of the recorded interviews. Although the level of detail that transcriptions contain will vary (Jovchelovitch & Bauer, 2000), for the purposes of this study, the "sifting and sorting [of] the text to identify categories most pertinent to the research question[s]" (Muller, 1999, p. 228) was employed. Once the transcriptions were completed, the process of constructing meaning and finding relationships in the data became the salient focus. "The emphasis here," explained Muller (1999), "is on [the] discovery of themes and patterns in the texts" (p. 229), through successive readings and critical reflection. Therefore, in order to discover commonalities in life events among participants, their respective stories were analyzed and compared thoroughly. As Riessman (1993) explained, "close and repeated listenings, coupled with methodic transcribing, often leads to insights that in turn shape how we choose to represent an interview narrative in our text" (p. 60). Then, in order to achieve internal consistency of *interpretation*, participants were encouraged to read through the researcher's extrapolations, and invited to clarify or edit elements of the narrative analysis that they felt inaccurately depicted their *life-story*. Finally, a *truthful* account of participants'

stories were presented to the reader to provide an in-depth, evocative understanding of the sensitive experiences of males afflicted with this debilitating disorder.

In narrative analysis, the researcher aspires to keep intact, as much as possible, the context of each individual story. To do so, however, requires that the researcher account for differences in experience across individuals. In commenting on participants' stories, *several voices*, including both personal and academic, were employed. As Ellis (1997) iterated, "sometimes this voice will call on authorities (i.e., citations), and sometimes it will call on thoughts and feelings I'm having as I write (i.e., experience)" (p. 120).

However, "voices from other texts, representing the extraneous happening and distractions of everyday life, also may intrude occasionally" (Ellis, p. 120). In an attempt to articulate the significance and meaning of these personal narratives, participants' stories were written in a manner where the details of their personal events and feelings cohered, thus resulting in the reader being able to participate more fully in the emotional process of these experiences. According to Coles (cited in Ellis, 1997), "the beauty of a good story is its openness" (p. 132) and its ability to evoke in readers a feeling that the experiences described were authentic, believable and possible. How the story resonated with its readers – how they *take it in* and use it for themselves – was of prime importance.

In any event, Jovchelovitch and Bauer (2000) emphasized the need for social researchers to be cognizant of the following statements when undertaking such analysis:

- Narratives privilege the reality of what is *experienced* by story-tellers: the reality of a narrative refers to what is *real* to the story-teller.
- Narratives do not copy the reality of the world outside themselves: they propose particular representations/interpretations of the world.

- Narratives are not open to proof, and cannot simply be judged as true or false: they express the truth of a point of view, of a specific location in space and time. (p. 72)

Ultimately, it is the attainment of “*narrative truth*,” which Spence (1982, p.28, cited in Ellis, 1997) described as “the criterion we use to decide when a certain experience has been captured to our satisfaction,” (p. 129) that defines evocative autoethnography. Narrative truth serves to keep the past alive in the present. As Ellis (1997) posited, it is only through narrative that “we learn to understand the meanings and significance of the past as incomplete, tentative, and revisable according to contingencies of present life circumstances and our projection of our lives into the future” (p. 129).

So Far Away

This is my life
It's not what it was before
All these feelings I've shared
And these are my dreams
That I'd never lived before
Somebody shake me 'cause I
I must be sleeping

Now that we're here, it's so far away
All the struggle we thought was in vain
All the mistakes, one life contained
They all finally start to go away
Now that we're here, it's so far away
And I feel like I can face the day
I can forgive, and I'm not ashamed
To be the person that I am today

These are my words
That I've never said before
I think I'm doing okay
And this is the smile
That I've never shown before
Somebody shake me 'cause I
I must be sleeping

- Staind

CHAPTER FOUR

The Narratives

Telling stories of ourselves in the past leads to the possibility of retellings. (Clandinin & Connelly, 2000, p.31)

Gary's Story: "Rise"

Shifting aimlessly in his chair, he settles himself, and quietly ponders his thoughts. He quickly succumbs to the silence, and in a soft-spoken drawl, offers the following revelation: "It's kind of weird because I openly talk about my alcoholism and addiction to drugs with people that I don't know very well. That seems to be far easier for me to do."

His voice tapers off. A brief lull in conversation ensues before he interjects moments later and clarifies why this might be: "Perhaps, it's because the stigma is not as great." Sadness pervades his face as he shares this newfound perception. It is patently clear that living with this secret has been extremely difficult for Gary, 31, a tortured perfectionist and recovering multi-addict. "It's abnormal to have an eating disorder, but to be a guy with one, it's that much more shameful and embarrassing."

Several years have elapsed since Gary's last episode but his penchant for recalling details about his pain-filled past is unnerving. Not long ago, he was relishing the new reality that embraced him: a life of frenetic expectation and impending fame. His successes were as varied as they were frequent. But at the earliest moment, though, he concedes that his remarkable success was not so much a story of resolve over adversity or faith over self-doubt as it was of placing "one addiction over another."

Unfortunately, though, sharing his story has been an arduous process. By nature, he is urbane, enthusiastic and decidedly optimistic. But though he is newly confident, sometimes an intermittent anxiety will plague him. Many, it seems, affect cynicism and disbelief at his admission that he was once bulimic. In response, he is now characteristically more cautious when speaking of his doleful past. “It’s sad really because no one ever expects a male to have [an eating disorder]. But they do. Look at me.”

* * * * *

As the second youngest of six, Gary grew up in a family best described as muddled and “dysfunctional.” The product of a broken home, he carries with him the mental and physical scars of a violent father. But, in spite of the many misfortunes that decimated his family during his childhood years – alcoholism, abuse, gambling, infidelity – his upbringing, he insists, was not completely bereft of pleasant memories. The difficult times, it seems, were just far more prevalent. As such, these memories are never far removed from his thoughts.

For many years, his father’s presence, or lack thereof, was the source of this unhappiness. As a result of his frequent absences, a lot of the childrearing responsibility fell squarely on the shoulders of his selfless mother. In an attempt to supplement the little money the family had – the majority of it squandered haplessly each week by his father to support his carnal vices – she found herself forced to find work outside the home, much against his wishes. But as trying and exhausting as it was for her, she continued to do so, all in the hope of keeping her children properly fed and clothed.

Over time, his father's fleeting tendencies, alcoholism and partiality for abusive behaviour would escalate, leaving both him and his siblings extremely fearful for their safety. The incessant fighting, he recalls, was traumatizing: "It robbed us of our self-esteem and from us believing in ourselves." Tellingly, his most pronounced memories are of him, as a scared five-year-old, hiding under his covers, his head buried beneath his pillow in an attempt to drown out his father's intensive screaming.

As time elapsed, however, the threat of physical violence began to frighten him more than the litany of personal put-downs he regularly incurred. Consequently, he learned to suppress his emotions. In doing so, he retreated further within himself, frequently abstaining from talking in the fear that he might be reprimanded harshly for his words. "It was like living with a guard and a controller rather than a father or a friend." But with each passing verbal insult, the need to please his father became less and less of a concern. This innate eagerness to placate eventually soon gave way to helplessness, followed by extreme indifference. By this time, though, the damage had already been inflicted.

Unable to establish and maintain close relationships, he continued to isolate himself further from the outside world. In doing so, however, the accompanying feelings of "shame" and "humiliation" were only compounded. Even in those rare instances of inclusion, he found himself tempered by caution. Such interest, he told himself, was only feigning.

I was sceptical [of others]. I didn't know how to relate to people and I didn't really have any social skills. I always felt alienated. I always felt like I had to prove myself. Being perfect [in everything] was one such way. If anything, I noticed early on that I wanted attention and approval. A lot of the things I found myself doing were because I wanted people to take notice...I was just searching for love and acceptance.

His chronic struggle to achieve perfection and validation manifested itself in an array of activities. As an avid collector of sport trading cards, it was imperative that all cards be stacked tidily and categorically numbered and organized into teams. He was resolute in his attempt to ensure their neatness. By age 10, he had begun washing and folding his own laundry and engaging in a variety of household chores, including the preparation of family meals.

Though hesitant to label himself as obsessive compulsive, he does, however, admit openly to being more concerned with cleanliness and order than most people. As a student, it was not uncommon for him to scrutinize over and rewrite pages of notes taken throughout the course of the day. His intention for doing so, though, had less to do with memory recall, and more to do with ensuring that his class notes were structured and neatly presented in appearance.

Although he was profoundly aware of the impracticability of being perfect, he continued to live his life in search of this ideal. “I always believed that if I were perfect, I would be a better person. I learned that this was a way for me to get some sort of control in my life, to compensate for the feelings of inadequacy.”

Gary’s early recollections reveal a child bereft of much happiness. Uppermost in his thoughts are those countless memories of having to look after and entertain himself on most days when no one –not even his own father – was willing to play with him. Just as distressing, meanwhile, were the long walks he had to endure across town to and from hockey practices and games, both in the early mornings and later evenings. As a means of “taking the power back” and retaining control over his sheltered life, he learned not to depend upon others, choosing instead to become entirely self-sufficient. “If I knew that

something had to be done, I would do it myself. That way, I knew it would be done properly.” He espoused this change almost immediately. He met expectations, upheld responsibilities and handled difficulties with an aplomb that belied his age. But though many uniformly praised his maturity, he still secretly retained a youth’s passions. “Deep down, I *wanted* to be a kid. Unfortunately, though, I also felt like I had no other choice but to grow up faster [than others my age].”

But in spite of this newfound independence, the misery, he soon discovered, would continue. Constantly teased by his peers for his overweight and rumpled appearance, his state of helplessness deepened, often giving way to critical apathy. In the open, he comported himself with ease, conveying a resiliency that obscured his youth. Secretly, however, he was writhing in pain. Over time, his black moods grew more frequent in duration, prompting much concern from his mother and the subsequent transferring of schools prior to the fourth grade. But, even then, the belittling and merciless heckling continued. In an attempt to counter this abrasive bullying, he often found himself resorting to fisticuffs, an act that, for the most part, proved futile and left him feeling more powerless. “Just being teased *once* was enough for me to mentally engrain the message [that I was different] into my head...I felt like I was constantly under a microscope.”

For the next several years, Gary would continue to endure this cyclical pattern of lows – weight gain, rabid teasing, fighting, heightened anxiety and plummeting self-esteem – only to grow more despondent and vulnerable when it didn’t stop. Upon his entry into high school, however, the harassment became less frequent, due in large part to having grown taller and “leaning out a bit.” But, despite this intermittent relief, he was

adamant about distancing himself from these unpleasant memories. Immediately after graduation, he left the surroundings that bore witness to this “personal hell” and moved into the city, intent on starting over.

Shortly thereafter, to compensate for the years of ridicule, he implemented a strict regimen of daily exercise that included exhaustive weight training and long-distance running. His obsession would intensify over the next three years. During this time, he would find himself consumed by the desire to compete competitively. However, in order to do this, help would be required. With the dual assistance of a renowned dietician and professional body builder, he was shown how to shed “twenty to thirty pounds of fat” off his already slender frame, all the while sustaining his lean muscle mass. Amazingly, he would do so in a mere six weeks. Unfortunately, though, Gary was only partially satisfied with the results of this makeover. Deep down, he knew he could still look better.

Intent on not having to relive the trauma of his earlier childhood, his desire to attain perfection deepened. Troubled by the thought of “being average,” he took steps to ensure that this fear did not become reality. Inevitably, his workout sessions began to increase, sometimes to twice daily. The results, he recalls, were astonishing. Aside from his dramatic physical transformation, other noteworthy, and equally important, changes ensued.

[Body-building] enhanced my self-confidence and my self-esteem. After having been overweight as a young kid, and then all of a sudden being physically fit, I noticed all the attention I was getting from both girls and guys. I was starting to have girls asking me to dance [at bars] and go out [on dates]...it was not uncommon to have a different girl every week. After a year or two, I was pretty buffed and guys were now approaching me and asking, ‘Will you help me out and give me a spot?’ or ‘How do you do this [lifting exercise]?’ Having gone from 5’8”, 155 pounds to 190 lbs. and being ripped and buffed with a six-pack

[stomach] and getting all that recognition made me feel really good. I finally began to feel wanted. At this point, things really started to change for me.

The most pronounced change being success. Nearly four years to the day after he first began lifting weights earnestly, he finished runner-up in his first professional body building competition, an impressive feat that would earn him many accolades, including a guest appearance on a popular local daytime talk show. His success, however, soon gave way to an insatiable compulsion. The gym began to take precedence over everything in his life, including work, school and family. Though he realized his obsessive tendencies to be sometimes “irrational,” he ardently clung onto the belief that his physical deficiencies were becoming more pronounced with each passing day. On occasion, he would inadvertently eye his “twig-like” image in the mirror, only to become increasingly distraught at the reflection staring intently back at him. He loathed his body in these instances, and it was not uncommon, he says, to berate himself, both publicly and privately, for his lack of discipline and fortitude.

Over time, however, the idea of attaining the perfect body began to consume his every thought. As his preoccupation with exercise and fat increased in severity, so, too, did his distorted self-image. Since it was difficult for him to conceive that other males might share similar concerns, he told no one else of these destructive thoughts, opting instead to suffer needlessly in silence. This unyielding mentality “to be the best” came to be reinforced daily, both by peers and the media. His friends, also avid bodybuilders, encouraged him to eat healthier, train harder, become stronger and – more fraught with expectation – “look better.”

But nothing, perhaps, might have been more influential, at his pinnacle, than that of the media. He concedes that the assortment of muscle and fitness magazines, weight-

training books and movies “were all *huge* motivators.” Bodybuilding icons, athletes, film stars were simultaneously idolized and vilified. In his view, they emanated power, success and virility. He, in turn, became obsessed, more than ever, with his physical appearance. His increasingly muscular and chiselled appearance – substantiated by excessive training and restrictive dieting – augmented this passion. “I wanted to look that good. Looking any other way would have paled [in comparison].”

Unfortunately, as he soon discovered, success was perilous. Fame, adulation and attention combined to create an unhealthy mindset. The consequences to his extreme behaviours became more glaring and, in the process, more difficult to ignore. Although he recalls his first purging experience to be accidental, he speaks of this happenstance with a gentle ease.

I had been dieting for eight weeks to the point of near starvation. After having been on this intense diet and losing twenty-five pounds of fat, the very next day [the competitors] were allowed to have anything we wanted to eat. I had been so tired of starving myself of salt, oils, and fats...everything was strict carbohydrates and protein. For the first time, I could eat whatever it was that I wanted. The taste of food was euphoric. I had pancakes with strawberries and whipped cream, bacon...a lot of greasy stuff that tasted good. I had a big heaping plate full. When I finished, I then went and had a second serving. I remember heaping [the plate] up as much as I could. I then went back and had a little more. By this time, everyone was laughing at me. I knew I was eating too much but I couldn't stop because it tasted so good.

A short while later, he found himself feeling unwell. In spite of his successful second place finish, and the feeling of elation that accompanied this endeavour, his thoughts were primarily centred around the copious amounts of food that sat uncomfortably in his stomach. In an attempt to find relief from this discomfort, he politely excused himself from the table and leisurely made his way to the washroom, careful not to invoke any concern, or suspicion, from his co-competitors. By the time he

had reached the door of the washroom, his stomach was churning uncontrollably. Almost immediately upon his entry he found himself cascading to the floor, bent over throwing up. Seemingly unfazed by what had transpired moments earlier, he tidied himself up and rejoined his friends. He would later dismiss this occurrence as nothing more than “a one-time thing.” Regrettably, though, this would prove to be only the beginning for his bulimic tendencies.

A year would elapse before his next episode. Over this time, his anxiety-wracked image would be complicated by depressed moods, constant fatigue and periodic insomnia. His depression, alas, would also be exacerbated by a series of traumatic happenings, all of which occurring within months of each other: a debilitating back injury, losing his job and mourning the passing of his father. Unbeknownst to many, these taxing hardships led Gary into a repetitive and laborious pattern of bingeing and purging. It seemed as the number of stressors increased, so, too, did his propensity for overindulging. This behaviour, once deemed fortuitous in nature, had suddenly become commonplace.

Losing my job was tough [for me]. I was actually let go because of [my] injury. My back got so bad that I couldn't even lift weights and being in the gym [was] what really made me happy. I had lost jobs before but losing this one in particular was difficult because I was twenty-seven years old and hoping to start a career. At that time, I had equated status with happiness...the idea of being physically fit and looking attractive was very important to me, it was engrained in me. Health and fitness was my life for seven years. My self-identity was dependent upon it. It was the only thing I could identify with that made me feel good about myself. When I found myself starting to get pretty down, I started to really turn to food for an escape. I would make specific trips to [the grocery store] to buy food so I could binge and purge. For a while, once a day, for about a half hour to an hour, all I would eat was junk food, or any [soft] foods that I would be able to bring up easy, like candy, cakes, ice creams, donuts and pies.

Tragically, over time, he found his incessant overeating to be reinforced, and

occasionally overshadowed, by his newfound compulsion for drugs. Marijuana, he recalls, provided “an escape” from having to deal with what he perceived to be life’s tragedies and insurmountable obstacles. Initially frightening, he eventually took comfort in its “therapeutic” value. Almost immediately from the outset, the two behaviours just seemed to feed off one another. His escalating drug use enhanced his feelings of hunger, prompting him to binge excessively – “past the point of being full” – only to be sick almost immediately after.

Naturally, in an attempt to conceal his behaviour, he would routinely engage in these destructive acts in the absence of others. He did so usually in late evening, long after others had made their way to bed. For Gary, this was just yet another way in which he alienated himself from the external world. Nevertheless, keeping others oblivious to this tendency proved difficult, especially in those instances whereby he and friends would attend social gatherings, frequent restaurants or “get stoned” while watching television and consuming massive quantities of junk food.

With each recurring episode, he became increasingly distressed and plagued by guilt. But in spite of lengthy periods of intermittent sickness, he continued to act out in this woeful manner. He hated himself for doing it, but his actions, he insists, had become “*so* incredibly addictive.” Not to mention punishing. If he were unable to lift weights, and take care of himself physically, he would then quell this desire by eating – a lot. “It was about being in control. It was all or nothing.” The mere thought of gaining weight – even the slightest – filled him with instant disgust and contempt. But as tiresome as his uncontrolled binges were, he was insistent on at least attempting to compensate for these calories. Purging, he recalls, helped serve to alleviate this fear of becoming fat. These

behaviours, however, were not simply restricted to the success he attained in the gym. Even in instances of marginal importance – not having much fun at the bar or going home alone at the end of the night – he would still become ostensibly depressed. On such occasions, it became common practice for him to buy an abundance of junk food, wallow in his self-pity and then purge.

Seeing that perceptions had been a preoccupation with him since early childhood, it was not surprising, then, that the perceived threat of others becoming aware of his disorder only aggravated this insecurity. As a recent university graduate, two-time provincial bodybuilding champion and successful mentor to troubled teens, Gary was extremely fearful that his image would be tarnished. Having attained many successes and accomplishments in his young life, it was bothersome for him to think that others would see him as weak or, worse yet, he says, “as bad or deviant.”

In a dire attempt to feel better about himself, he soon began to associate with an unruly group of individuals whose love for drugs far outweighed his interest. But his inability to cope with his growing addictions became compounded by his family’s absence. His circle of friends had begun to diminish, leaving him with only mere acquaintances. Alone in a new city trying desperately to combat his ailing problems, he recognized his need for counselling but quickly dismissed the idea. “I didn’t think that it would help. I wasn’t sure anyone would really understand. A male, after all, was *not* supposed to have this [disorder].”

Motivated in large part by fear, he voluntarily sought out professional help a short while later. A month had passed since his last episode and his impulses to binge were not being curbed, despite his best efforts. After innumerable conversations with nurses and

dieticians, an appointment with a prominent psychiatrist was eventually scheduled. Unfortunately, much to his dismay, the meetings offered very little assistance. He had been hoping for some insight as to why he might be maintaining these malign behaviours, but, sadly, he never received any. “We never got to discuss what was actually going on behind the eating disorder. All the important stuff – the feelings, emotions, how I felt about myself and others, life in general – never once came up.”

Dejected with this lack of help, he left Saskatoon shortly thereafter and returned home. Weeks later, and after much deliberation, he relocated to Edmonton. The impetus for the move, however, was not rooted in seeking out treatment for his disorder, but rather as a means of placing more distance between himself and his problems: “a geographical cure, if you will.” As it turned out, a series of disheartening and incidental happenings would also contribute to his leaving. Only upon his arrival home did his mother, and other family members, unfortunately become aware of his eating disorder. Most memorable, he says, were those occasions in which his mother stumbled haplessly upon him purging uncontrollably in the washroom. Such a sight, predictably, left his mother mortified; the accompanying awkwardness and humiliation left him overwhelmed. Having found out the way she did only reinforced his decision to leave home. He convinced himself that the impending move would bring forth positive change – a change for the better. And in some ways, it did, but eventually, he adds, “things began to snowball out of control.”

In dire need of this new beginning, he enthusiastically set off, accepting his brother’s invitation to move in with him. His grave attempt to reconstruct his life began almost immediately. But though he had aspirations to change, he found himself, at the

time, consumed with, and discouraged by, his past. His back injury and absent career began to take priority over everything else, leaving him, on most days, with strong inclinations to revert to familiar habits. Fortunately, within three weeks of his arrival, he was happily employed, working busily in the inner city with troubled and disadvantaged youths. More importantly, meanwhile, his newfound employment had garnered less compulsion to visit the gym on a daily basis. The satisfaction that he now amassed from working and earning money and making new friends imbued him with a belief that all would be fine. But despite this palpable sense of optimism, his happiness – the very little that he grasped onto – would recede, giving way to more ruinous and lasting behaviours.

Nearly a year would elapse before his eating behaviours progressively worsened. The untimely loss of his job, accompanied by an inability to offset mounting financial expenses, sent him reeling in despair. In an attempt to defuse this anguish, he began smoking marijuana more than ever before. This coupled with an unabating tendency for frequenting underground clubs and raves, where alcohol and assorted drugs were rampant and available in vast quantities, only compounded this chronic anxiety.

Almost immediately, his excessive and unremitting use of marijuana began to affect his eating behaviours. In turn, he fell prey to this vicious circle of drugs and over-eating and purging, once again. But though these behaviours would carry on erratically for the next several months, changes were slowly becoming apparent. Amazingly, as his involvement with drugs and alcohol began to intensify, his concurrent relationship with food began to abate. He discovered in those unwonted instances of over-eating, the act of purging often resulted in excruciating stomach pain and spitting up bile. Such agony, he says, quickly came to be a powerful deterrent for future impulses to binge. But nothing,

perhaps, might have impeded these urges more than his newly minted dependency. This fact, it seems, is not lost upon him. “The *drugs* saved me. I recognize that now, and I am somewhat grateful for it. But, unfortunately, I now have to deal with those consequences.”

* * * * *

A quiet confidence has come over Gary, the kind that comes with time and after tribulations. He now carries with him a profound sense of wisdom. There is also an accompanying sense of empowerment. As he reflects upon these earlier struggles, he is mindful of the lessons that have been inculcated to him. Since then, he has chosen to immerse himself in these learnings.

One of the biggest things that I have learned through my addictions is the importance of being honest, both with myself and with others. If you're not honest, and accept having a problem, you will never be able to deal with it effectively. I've also had to learn to make myself happy, without [depending on] anyone or anything else to make me feel better...and I'm still only learning to do this. I've since learned how to deal with my fears, whether that be the fear of rejection or the fear of failure, and how to face life head on...in addition to having to learn how to cope with life more constructively because when you don't cope with life in a healthy way, things will spiral downward and only become worse. The more I engaged in unhealthy eating behaviours, the more difficult it became for me to open up [to others]. I was just basically digging a deeper and deeper hole for myself. All I was doing was hiding [the problem]. In doing so, I was alienating myself and making it that much more of a problem.

But of the many lessons that have intensely affected his life in recent years, however, none might be more salient, or has been more effective, than his learning how to communicate. Unlike before, Gary now understands the importance of talking with others about his problems, regardless of what or how many there are. Conjointly, asking for help is now held in high regard. As is humility, it seems. He now believes success as not something tangible, but rather a feeling.

More importantly, however, his preoccupation with physical image and garnering attention is now of very little concern to him. Approval is no longer conditional on having to look a certain way. “How I come across to others – my personality, attitudes and behaviours – is much more important to me now than how I look. I live by that belief now and I’m happier [as a result].”

A more compelling explanation for this change in thinking, though, rests almost entirely on the people Gary now associates with. The myriad of conversations he routinely engages in with health-care professionals, namely psychologists and addictions counsellors, continues to inspire, educate and ground him. He also attributes having a supportive network of peers and attending semi-weekly meetings for his current alcohol and drug addiction as having reinforced this change. Of particular comfort, however, has been the number of others he has encountered throughout the course of treatment who have experienced similar adversity and who have prevailed. He is confident that he, too, will achieve similar success one day, even if it does require a lifetime commitment on his part.

Publicly, Gary relishes the success he has attained with his eating disorder. As such, he is now no longer as contrite when speaking about his indelible past. He tiredly describes his past obsession with food and dieting as “just wrong,” not to mention “unhealthy.” If anything, he is very appreciative of how “lucky” he has been. Aside from now being able to enjoy food in moderation, he no longer possesses the need to have to count calories at each sitting. For the most part, acknowledging his drug dependency has been effortless in comparison to revealing his storied past with bulimia.

This distinction, he delicately offers, is largely imputable to being afflicted with an illness that is more “socially accepted” and expected from males in modern society.

Privately, though, he acknowledges his fear of relapse. Though the impulse to overindulge in food remains, albeit occasionally, he has since learned to identify the “stressors” behind these urges, and, unlike in his past, notice when he is full. But, in spite of this concern, he does firmly believe that the worst is behind him. In fact, he adamantly believes that one day he will be able to body build again, though not competitively. Instead, he will do so for the right reason: “for the fun of it.” He still aspires to be physically fit, but not if it comes at the expense of his fragile health. Unfortunately, though, if past is prologue, Gary’s vulnerability, and resiliency to, chaos and despair will surely again resurface. He professes openly to having “an addictive personality,” always actively searching for an appropriate outlet for these compulsions.

But though Gary readily acknowledges that many will not comprehend the reasons behind the necessity for his eating disorder, he takes solace in the invaluable function it has served him, that of a coping mechanism. “I needed it. At that point in time in my life, my eating disorder was the *only* thing that was safe and that others couldn’t control.” Even now, he remains obstinate in its importance. He truly believes that his past will turn out to be “a blessing,” not only for himself, but also for those privileged others with whom he intends sharing his personal story in the near future as part of his healing process.

More profoundly felt, perhaps, is the belief that success is ultimately determined by one’s ability to accept past indiscretions and mistakes. The ability to forgive, both himself and others, has been of critical importance throughout his time in recovery. He

readily recognizes that others are just as fallible as he is, if not more so. In fact, only after brushing aside all the anguish and resentment of his early childhood, was he able, he says, to take corrective action. In the process, he began to feel better, both about himself and his chances for recovery. “If I was ever going to get better, I needed to remain positive. Being angry would not have helped [me].”

Though he acknowledges his current satisfaction may have been difficult to attain, he does adamantly believe it is much deserved. Finally, his life has achieved some sort of peace. He contends he is much “stronger” for having experienced these difficulties and, more importantly, having learned how to effectually deal with them. Remarkably, he has no regrets, past or present. After all, in many ways, he says, these experiences have “made me who I am today.”

If anything, Gary is much more apt to assess the merits of his accomplishments. He does not wish to extricate himself from his past; he would much rather use these experiences as something positive and learn from his mistakes. Instead, predictably, he chooses to enthuse about his future, a life of infinite possibilities, renewed health and further learning. “I’ve suffered a lot in my life. I will never forget that...but I will also never allow that to happen again.”

Weapon

Here by my side an angel
Here by my side the devil
Never turn your back on me
Never turn your back on me again
Here by my side it's heaven

Here by my side you are destruction
Here by my side a new colour to paint the world
Never turn your back on it
Never turn your back on it again
Here by my side it's heaven

Careful, you be careful
This is where the world drops off
Careful, you be careful

And you breathe in and you breathe out for it
Ain't it so weird how it makes you a weapon
And you give in and you give out for it
Ain't it so weird how it makes you a weapon
Never turn your back on it
Never turn your back on it again

- Matthew Good

Adam's Story: "Come Undone"

Not long ago, in the divided soul of a 23-year-old multi-addict, Adam, a shy, self-critical enigma, was locked in mortal combat with a relentlessly driven urge to die. The unsettling images of death that overwhelmed his thoughts were as varied and perpetual as the secrets and demons that had haunted him for years. At the time, his life had been marked and decimated by an array of hardships and tragedy: anorexia nervosa with binge-eating and purging tendencies, clinical depression, panic disorder, weak family dynamic, bullying and drug abuse. Treatment, he figured, would not subdue this desire, but only prolong the inevitable. "I didn't want to go on. I just wanted to die."

Today, however, the thought of dying is no longer as alluring. Rather, he has ensconced himself to the reality that recovery from anorexia is possible, even if not immediate. Although the sense of fragility and mortality that accompanies his eating disorder is extant, the once mercurial and evasive young man is now more apt to enthuse about his renewed positive outlook and varied accomplishments. More remarkably, though, is how affable, funny and preposterously poised he is as he speaks of his painful past. He is intelligent and articulate, but still capable of gentle self-deprecation. Acutely aware of his inability to erase humiliations past, he lingers on, feverishly awaiting the day when his life is no longer marred by undue hurt and helplessness.

But lost among the tumult surrounding Adam, for many years, was his family, an endearing and loving source of support, but patent contributors to this tragic self-hurt. Having grown up in a competitive, upper-middle-class family, he lived his life saddled with expectations and exacting standards. "Weight and body image was of significant concern in our family. I definitely think that set the stage for my eating disorder to

develop.” From an early age, the message was succinct: do not become fat. Ironically, such sentiments were often expressed to him in times whereby others, particularly his sister, jokingly referred to him as a “Holocaust victim,” because of his already gaunt appearance and fussy eating habits. In fact, in order to ensure that he would eat, all of his meals were carefully catered and cooked according to his likes, even if that meant separate meals had to be prepared, thrice daily. Mealtimes, he recalls, often resembled a “battleground” in which both of his parents would argue endlessly over whether or not the diminutive six-year-old was expected to eat. Adam, naturally, came to view this constant bickering as a primary and effective means of exerting his growing independence and control over others.

But nothing, perhaps, might have been more arduous than his mother’s recurrent tendency to safeguard him and his sister from becoming overweight. Fearful that her poor genetics might have been passed onto them, stringent precautions were taken in an attempt to ensure their slimness, including pressures to participate in sports and food restriction. Unfortunately for Adam, his initial waning, and eventual inactive, interest in sports was met with much disappointment from his parents. Consequently, they now had to extol the values of being hale and thin through other means. One such way, for example, was for his mother to refrain from buying foods that she deemed to be too unhealthy. Junk food, he recalls, even in moderation, was strictly verboten. “I often found myself sneaking behind her back just to eat it. I believe that played a major role in the start of my binge eating.”

By adolescence, however, this intrusive parental supervision had abated, due in

large part to his mother working outside the home and having less time to closely monitor his and his sister's everyday behaviours. Not surprisingly, both he and his sister embraced this unfamiliar freedom, often resorting to binge eating as a means of passing time. Adam, though, espoused food for more poignant reasons. Eating, he recalls, served to combat the years of incessant and injurious teasing he endured for a speech impediment and poor social skills.

Naturally, though, this overeating was not without its implications. Sixty plus pounds heavier, Adam became burdened by extreme guilt. His overweight and unkempt appearance had now upended every expectation that had been placed upon him to be thin. As such, he soon found himself engrossed in a strict dieting regime, often consisting of one or two small meals per day – a piece of toast for breakfast and a low-fat muffin for dinner. Through dieting, occasional purging – an act first introduced to him years earlier by his sister as a way of controlling her own weight – and “the magic of drugs,” namely ecstasy and cocaine, Adam was able to shed the excess weight and return to his pre-binging weight of 150 pounds. Sadly, though, this success only begat a stronger desire to lose more.

His substantial adolescent turmoil would later become compounded by the untimely dissolution of a lengthy relationship – one that eventually culminated in he and his then girlfriend giving up their infant son to adoption – and an increasing pressure, most notably from his ex, to lose further weight. In a dire attempt to expedite this weight loss, he began to run five miles a day, three days a week and restrict his daily food intake to one “mini-meal,” despite being chronically hungry. His days, by all accounts, were seemingly structured and regimented. Each morning, he would wake up long after his

parents had left for the day, exercise, go to work, eat a late dinner and then purge immediately after, a behaviour that had now become more intense and frequent in duration. Later on in the evenings, he would convene with friends and drink until exhaustion, or sometimes more troubling, until he passed out. Regrettably, he continued to indulge in this destructive pattern of living and he did so knowingly, mindful of the unhealthy circumstances. But even though he managed to discard 15 pounds over a span of five weeks, the thought of losing additional weight was still paramount to him.

Fearful that his behaviours were now beginning to invoke parental concern, Adam chose to distance himself from his problematic life. He left Victoria, a landmark of sullen memories, and relocated to Edmonton, eventually settling in with his sister and her fiancé. The move, he acknowledges, was both impending and inevitable. But, unbeknownst to many, the move also carried with it a more perilous motive. “When I moved, I basically planned on being dead or in the hospital within a year. I thought that just based on how quickly I had been losing weight and how I still wanted to lose more.” In addition to binging and purging more regularly, his appetite for designer drugs had become more rapacious. His intemperance for crystal methane and coke had heightened and he subsequently found himself ingesting the stimulants daily as a means of curbing his appetite. Not surprisingly, he quickly regressed back to his accustomed routine of sleeping in late, going to work, fasting all day and then binging and purging upon his arrival home. He drastically lost another 25 pounds as a result.

But in spite of this dramatic weight loss, it remained almost unimaginable – at 5’6” and 110 pounds – to picture a life bereft of hurt and anguish. Instead, for sundry reasons, he continued to immerse himself in this disordered state of being. This was none

more apparent than in his unremitting pursuit to become “hollow” and concave-like in appearance. Alarming, such success was often gauged late at night while lying in bed, a ruler strategically aligned across his pelvis. The relative ease with which he was able to slide his open hand under the ruler ultimately determined how much more weight needed to be lost. For Adam, to appear sickly was to externalize the inner pain that persistently crippled him. “When I saw myself in the mirror and looked sick, it made me happy because it was a reflection of how I felt. There was no other way for me to express how badly I was suffering.”

Even more unsettling, though, was the tranquility he felt as a result of this noxious starvation. During such episodes, it was not uncommon, he says, to abstain from eating for days on end, a disturbing trend that still occasionally devastates him. Having grown tired of the anxiety-provoking thoughts that inundated him on a daily basis, he cherished the reprieve that his mind afforded him by not operating at peak capacity. In such instances, any thoughts he had pertaining to his future, let alone the next day, were rare and fleeting.

One of the most appealing things of [having] an eating disorder is that when you're just so weak that you have to climb up the stairs on all fours, you can't be bothered to sit there and analyze your future and your life and what you're going to do and how you're going to pay your bills. The challenge lies just getting around because every time you stand up, you black out. [When that happens], everything else in your life just sort of takes a backseat. It provides this enormous distraction – you don't have to worry about things that really terrify you...[but] once you decide to recover, you are now [forced to face] the future...your life now feels very dull in comparison to the drama of an eating disorder.

Tragically, his inordinate suffering was exacerbated by chronic anxiety, a terrifying condition that frequently rendered him immobile and unable to speak. The attacks, he recalls, were unrelenting and elicited strong feelings of panic and fear. His

earliest – and most rife – memory was of him, as a five-year-old, sifting through his father’s hunting gear and stealing bullets, using the gunpowder encased within to try and build bombs. He did so, he says, as a desperate attempt to alleviate the continual “sense of impending doom,” a devastating feeling he now vividly equates to “living with and being inside” an eating disorder.

Over time, these dangers would be augmented further by a penchant for shoplifting, an act for which he would later be arrested and fined for. He maintains his reasons for indulging in such erratic behaviour were twofold: to replenish his diminishing wardrobe and “to break the rules.” As a result of his dramatic weight loss, his clothing, once comfortably fitted, had now become increasingly oversized for his tiny, willowy frame. Instead, to ensure that clothing now properly fit, he often found himself stealing women’s jeans and t-shirts, only to later shrink them even smaller upon his arrival home.

In the wake of these transgressions, though, an even more compelling motivator surfaced: rebellion. Although theft served as a welcomed distraction from his episodic binging, he found the impetus for committing these harrowing acts to be surprisingly similar: both were clearly excessive and dangerous to a fault. Moreover, the possibility of getting caught was invigorating. The energy, he adds, was “undeniable.”

Sadly, so was his sister’s ubiquitous presence. Once a profound trigger for his unhealthy eating behaviours, her influence is now only moderately felt, much to his relief. He attributes having to eat all of his meals at the hospital, four times daily, as a major reason behind this solace. But there was a time – many in fact – where he found it increasingly difficult to sustain a regular eating schedule in the presence of his sister, a chronic dieter and aesthetic enthusiast herself.

Most distressing, in particular, were those instances in which she would adamantly press him to diet with her, even though it was patently clear he was sickly underweight. “I knew that she just wanted someone to diet with her to make it easier but it was hard [to deal with]. When I would choose not to, she would look at me in horror and ask: ‘Are you not terrified of gaining the weight back?’” Unfortunately, his recent fondness for cross-dressing has done very little to diminish this shared influence: “I’m a big trigger for her because I’ve been dressing up in drag recently and her clothes are too big for me. I’ve now triggered her to lose weight [as a result].”

For Adam, waking up each morning and forcing himself to eat was an arduous process, especially on those days when he would not see his sister eat for the first time until late in the evening. “It was very hard to convince myself to eat three meals a day when *normal* people around me were not doing that. I used that as justification that [my] extreme measures were acceptable.”

Unfortunately, his frail and weathered appearance was now beginning to incite intense looks from those nearby. Some viewed his emaciation as shameful, motivated, in large part, by a grave need to garner attention. Others, however, saw it as a seminal expression of teen angst. He, in turn, dismissed these wrongful accusations as nothing more than blatant ignorance. But at the earliest moment, he concedes that there was partial appeal in looking skeletal. “When others would ask if I was anaemic, or had cancer, it was reinforcing. I felt like I must have been on the right track to looking sick.” Yet, in spite of all of this, he continued to deny that he had a problem. Lying became a commonplace occurrence, as did his proneness to detach himself further from loved ones.

“Everyone pretty much knew I had a problem. It just wasn’t talked about because no one knew how to broach the subject.”

Tragically, Adam’s misery would heighten to a treacherous climax months later after arriving home from work in a panicked and incapacitated state, his blood glucose level measuring almost nil. At the urging of his distraught sister, he was rushed by ambulance to the emergency room. But the events that had precipitated this impromptu visit were just as distressing as the relief and happiness he felt knowing that he was close to dying. Feeling disgusted with himself after having gained weight during a recent visit to his parents home a week earlier, he consciously set out to regain control and lose the excess weight. His self-destructive rampage would last for nearly a week, his fasting interrupted by the occasional binge and purge and compounded by severe panic attacks and extreme laxative, diuretic, and stimulant abuse.

Recognizing that his oft-spoken wish – to die at perfection while maintaining complete control over his demise – might not be far from realization, Adam, his pallid complexion and muffled speech deteriorating with each passing moment, calmed himself and awaited his fate. En route to the hospital, he had rejected all attempts made by paramedics to inject glucose into his veins. To do so would only keep him alive longer and, more distressingly, infuse his body full of unwanted and calorie-induced sugars. For that reason alone, he welcomed death.

However, upon his arrival, an unexpected turn of events emerged. Surprisingly, his calamitous outlook was replaced with an urgency to live. The tears and sorrow that enveloped his sister’s face as she sat by his bedside prompted him to request saline and intermittent doses of glucose. He would endure this painful process throughout the night,

during which time he would resign himself to the idea of treatment. Although the internal struggle to live or die would continue to torment him, he would ultimately, in the end, dedicate himself to the confines of recovery. He would do so, however, for no other reason than to appease his family's wishes.

It is apparent that Adam, his visage a picture of self-inflicted suffering, is not comfortable with the idea of normalcy, a term frequently employed, often patronizingly, by the many professionals treating him. In fact, he finds himself to be an unwilling participant in this quest. Over the course of treatment, he has searched longingly for an example of what "normal looks like," only to wind up exasperated and thoroughly convinced that "no such thing exists." Aspiring to be normal, he reasons, is predicated on expectations – expectations brought forth, most notably, from others. Sadly, for him, and for the many others currently undergoing treatment, it is these same expectations that have played a defining role in the onset of their disordered eating and continue to hazardously reinforce these behaviours today.

Moreover, this steadfast belief is not just restricted to the perils of his eating disorder. In fact, even normal life frustrates him. He finds the monotony of engaging in everyday behaviours – attending school, going to work, paying the bills, eating, etc. – to be rather boring. Conforming to convention, he argues, is not dramatic; struggling to fit in without compromise is, however. "A lifestyle like that would leave me in quite a panic. It would feel really dreary. I can't imagine where the *excitement* would be."

Not long ago, fathoming a life without his eating disorder was enough to induce a crippling amount of panic in him. In fact, prior to entering into treatment, he found himself to be terribly depressed and violently suicidal. In addition to hoarding massive

quantities of prescription medication, he made sure that an abundance of razorblades, and other sharp objects, were available and in close proximity. He did so, he now admits, as a safety measure, in the remote chance that he was unable to endure the demands of recovery. The bad days, less frequent than in months past, continue to haunt him, as does the temptation for self-harm. But in spite of these wavering temptations, he remains resilient and hopeful, professing a sincere desire to convalesce.

Upon reflection, though, he willingly acknowledges that his reasons, once selfless, are now much more expedient. He is immediately forthright when addressing this issue:

At first, it was just a lot of guilt about not wanting to hurt my family. I didn't really care enough about myself to want to recover, but I cared enough about how [my death] would hurt them. I didn't want to torture them anymore...[But now], I have managed to convince myself that I wouldn't be dying at perfection, but rather as a pathetic, sad case. I see [my death] as being this big dramatic thing, but that's not the message that would be seen by anyone else. [Instead], all they would say is, 'that kid wanted to be thin so badly that he starved himself to death. That's such a shame. [Even worse], he knew he was doing it because he was studying health sciences [in university]. How's that possible? What a sad story.' Then, they would flip the page of the newspaper and read something else.

This revelation is a testament to Adam's propensity to speak the truth, an attractive quality, but one that has, unfortunately, led to many acrimonious arguments with hospital staff and a recent one-week suspension from treatment. Nevertheless, he remains remarkably candid and outspoken about the progress he has made thus far. Alas, these changes appear to provoke both smiles and corresponding frowns. Aside from gaining weight, a necessary evil that continues to be an occasional source of discontent for him, he now finds himself in no immediate hurry to acquiesce to others. Aside from a disconcerting ability to say exactly what he is thinking, he now speaks up for himself if he feels assailed. He is also uncharacteristically more honest, with himself and with

others, since his entry into recovery. The compulsion to lie about his eating disorder, keep secrets and hurt others is just senseless now, not to mention taxing. Additionally, he is no longer averse to expanding his social circle. If anything, he welcomes the noticeable change in being able to socialize again with people. More importantly, and less embarrassingly, though, he is able to hold a conversation without the fear of his mind drifting off.

Conjointly, though, it is these same newfound behaviours that terrify him. Since he has started to eat again, he no longer experiences the weekly blackouts and the regular occurrence of hypertension. Instead, much to his dismay, he finds himself to have more energy. Occasionally, though, his “sick side” becomes so frightened by all of this that he retreats into an immediate relapse, just to prove to himself that he is still able. Reverting to these old, familiar behaviours becomes, once again, comforting and safe. “It’s a sign that I am doing things right. I feel like I still have control.”

But, to Adam, the ability to feel is a miraculous accomplishment in itself. In fact, only up until recently has he been able to experience what hunger feels like. Eating, it seems, is no longer primarily engaged in with the intention of burying feelings but rather as a means of alleviating actual stomach hunger. Much of this progress, he willingly acknowledges, is the direct result of learning how to communicate more effectively with others. Although very pleasing to him, it is also very terrifying. This is not necessarily surprising, though, especially when considering he has spent the majority of his life suppressing his emotions and isolating himself, all the while playing the malcontent, a role in which he overtly reverts. But this isolation, it seems, appears to differ in extremes, depending upon the individual. “Some people are just very angry with the

world. It's almost a rejection of the world's expectations, or even of family expectations. For others, it's just an extreme desire to please." On occasion, Adam finds himself torn somewhere in between. Regardless of the motivation, though, both prove to be irrefutable in importance. The means, however varied, always lead to similar ends: control and justification.

But, perhaps, more compelling than the reasons for needing the disorder are the contributing reasons behind having one. Adam, for example, is quick to concede that the media and cultural influences imbued him with extreme sadness and torment. It seems each time he visited the gym, he would unfailingly end up feeling worse about himself and his body. "The magazines gave more attention on what I should change, rather than promoting exercise as something I should do because it's healthy." More upsetting, however, was the reinforced belief that such a perfect image could be arrived at naturally by anyone who expressed enough conviction to want to change. He frequently denounced this ideal to be "unrealistic" and "utter bullshit."

Adam contends that these reviled comments have been, and will surely be, misconstrued by many as nothing more than jealousy, or even worse, indolence on his part to attain this desired change. But, as inevitable as this may be, he remains rational and resolute in his belief: Society is accepting of an unhealthy body image as long as it is physically appealing.

That idea of body as being completely malleable is promoted throughout all sorts of media and cultural influences. As much as we'd like to pretend that it's not, [the messages are there] that fat people get treated differently – they're frequently stereotyped as being lazy or as having no self-control. It becomes quite natural for me to then internalize and think of the anti-thesis – to be thin is to be controlled and reserved; to be overweight is to be unsuccessful...every one of us does it on some unconscious level, [comparable to the way] we treat men and women differently. And for some reason, some of us are much more affected by

that perception [than others]. We find ourselves wanting to be on the side that says, 'I want to be thin'...I also believe that this affects men more than they care to let on. It's kind of feminizing, almost as if you're giving up a piece of your masculinity, if you care about your appearance...but you still do it because that's what you have to look like [if you want to fit in and be noticed].

Nowhere, though, is this harsh reality truer, and continually reinforced, than within the gay community. To present as a gay male is to be aesthetically pleasing – extremely muscular or extremely thin, but never in between. In fact, the immediate social implications are just as distinguishing as the body types themselves – fervent adoration or blatant disregard. But even in those instances of extreme adulation – most notably, the considerable number of unwelcome advances Adam endured from other males hoping to act upon their vile, “skinny boy” fetishes – the repercussions were just as pronounced.

These disgusting comments often prompted Adam to reciprocate with a fusillade of disparaging comments of his own. But, despite his best efforts to be truthful – that he was a recovering anorectic; that he should have body fat; and that he did not prefer his wafer-like appearance – the end result was always the same. Their apologies, as frequent as they were trite, did very little to alleviate the resentment he harboured. Many, unfortunately, still could not grasp the idea that what he had done to himself was not healthy. Rather, they continued to praise him for his bony appearance and zero body fat.

But even after having been privy to such inane remarks, Adam remains stoic and optimistic about his immediate future. While he acknowledges that this process has clearly ravaged him, he insists that his recovery will grind on without undue family participation or worry. As a means of ensuring this, he often refrains from sharing with

them the exhausting details of those difficult days in treatment. Instead, he finds himself drawn to those empathic few on the unit who share similar misfortunes and heartache.

He is quick to purport, though, that this ability to relate is not dependent, as many might presume, upon which gender one embodies. If anything, he seems to find more commonalities between the sexes than discrepancies. Where they are not, however, lies in the amount of attention afforded to them, most notably by the media, and to a lesser extent, by the medical community. Even though he views male eating disorders as becoming more prevalent, the topic itself, he says, remains “taboo,” steeped in ridicule and shame. Many males seem to eschew the idea of admitting they are less than fully male in a society that reveres masculinity. “You never hear about a guy telling his story of an eating disorder. It’s always a girl. They’re the ones that need the help.”

For Adam, there was a feeling of isolation that accompanied this spoken truth. A feeling that suggested he was the only one, but more alarmingly, a feeling that suggested he had to help himself because no one else, not even medical professionals, could assist him in this process. A few, sadly, even had the effrontery to imply that males were not susceptible to this disorder. But as unresponsive as they were and as disquieting as it was to hear, he knew otherwise. There were others. Some he had even met. Unfortunately, though, he continued to find himself the unwilling recipient of cynical looks and innocuous chatter. However, in spite of this indifference, he remained composed and confident that such insurmountable odds could be overcome. After all, he reasoned, there were far more unenviable positions to be in: “I can’t imagine how much more difficult [seeking out treatment] would have been had I been a straight male. There might have been this misperception that I was [gay] when I wasn’t.”

Fortunately, he does not have to contend with this additional complication. Instead, he immerses himself into treatment, seven days a week, without the fear of having to rationalize why he has a “woman’s disease.” He cites his sexuality as having enabled him to do this for it is much more acceptable to be anorexic when you embrace a gay lifestyle. But in spite of this reputable fact, it has not made his recovery process any less demanding, or daunting. The strict stipulations that have been placed upon him during treatment have left him, on most days, extremely apathetic and visibly fatigued. Recovery, for the most part, has become his whole life.

But far more trying to him than preparing himself for a lifetime of recovery is how he arrived at such a predicament in the first place. He, like so many others who share similar struggles, never once thought he would fall prey to such a debilitating disorder. Initially thinking he might begin to take on the behaviours of disordered eating, he later affected shock at the realization that he had been “swallowed” by it. Luckily, though, this engulfment has become less imprisoning. Unlike before, he is now less apt to dismiss the possibility of ever recovering. But in spite of this startling admittance, he is just as quick to express his reservations. This is not necessarily unforeseen, though, especially when considering the strong, and almost inevitable, possibility of relapse.

For Adam, the possibility of such an occurrence is anguishing. It is not surprising, then, that he expresses an adamant desire to endure this recovery process only once. Anything more, he reasons, would only compound his anxiety and lessen his chances of ever recovering. Although medication has aided him in his recovery process, he does express trepidation in becoming too dependent upon these drugs. As a recovering addict, he is cognizant that such a relapse would only further complicate the

treatment for his eating disorder. By now self-limiting his prescription intake, he is hopeful that such a fear will be quelled, if only in the interim. As for his future, he is much more uncertain. He terrifyingly announces that the thought of not having these drugs “to help shut everything down” consumes him and will probably continue to do so as long as he is expected to gain more weight.

His treatment, a combination of behavioural modification and individual therapy, is just as rigid and demanding as the professionals responsible for enforcing these changes on a daily basis. In an attempt to restore normal eating behaviours, strict protocols outlining expectations for weekly average weight gain are implemented and vigorously adhered to. Just as wearisome, however, is the waiting period after meals – four times daily and lasting sometimes up to one hour – whereby he and other patients are monitored to ensure that their purging behaviours are attenuated. But nothing, perhaps, has been more distressing to Adam than the unyielding “all-or-none” mentality that a few professionals have chosen to adopt in their treatment of these abnormal eating behaviours.

I think it's ironic that they take on [this] approach to healing, especially when considering an eating disorder began [as a result of] all-or-none thinking. To me, it's much more important to introduce a grey area where it's not a matter of you being anorexic or you being recovered. Instead, they should be setting an example for us, [teaching us] that there is a sliding scale here. Otherwise, it just [sends the message] that you are either fat or thin – there's only perfection or failure...It only supports the belief that we have always had – that there are only two ways of thinking...[prior to coming here], I had just spent three months learning how not to think like that and now that's the way [they're] discussing things with me.

In spite of these contentious relationships, though, Adam remains relatively satisfied with his current treatment. As difficult as it has been at times to renounce control over his eating disorder, he has done so anyway, all in the hope of recovering

from an illness that has plagued him for nearly a quarter of his life. On any given day, he continues to struggle wearily with the impulse to lose weight. Yet, ironically, he is the first to admit that losing additional weight would not make him look any more attractive, or more importantly, make him feel any better about himself as a person. He does not bemoan his personal travails, nor is he quick to project blame onto others for these hardships. In fact, much more stressing to him than either of the aforementioned is the thought of invoking sympathy from others as a result of them.

But while Adam readily admits to being personally proud of his achievements, he also does not feel compelled to pronounce this success onto others. Aside from attracting unnecessary attention, doing so, he figures, would only prove fruitless: “How can you possibly explain to someone what an accomplishment it is when they don’t even know how much of a struggle it’s been?” Such unawareness, though, is comforting to Adam. After all, it has never been his intention to be understood. Rather, much more important to him than this improbable occurrence is to have his story heard, both genuinely and objectively.

And even though a few, despite hearing graphic details of his struggles with food, still proceed to profess ignorance, he continues to forge ahead, unwavering and without much worry. He is not content in burying himself with this burden anymore. Those days appear to be fading. Hopefulness now prevails, as does the proclivity for laughter. “The encouragement gets me through...as does the humour. I find that if I can’t make fun of my own behaviours, then how am I ever going to get over and accept them as being absurd?”

But if Adam has learned, and is eager to share, one thing over the past few

months, it is this: Although his life has been full of adversity and sorrow, much of it without any clear meaning, a comical side does exist. “We’re kind of a joke. We’re a weird little group of people. I mean, really, how can anyone possibly be intimidated by someone who is afraid of mashed potatoes?”

CHAPTER FIVE

Conclusions, Discussion and Recommendations

This study functioned exclusively within a qualitative framework. Data were collected primarily through the utilization of two active, unstructured interviews. In an attempt to clarify issues raised and explore mitigating concerns and commonalities, a third interview was employed, providing further opportunity for participants to make meaning of their experiences. These interviews were then plied to gather *narrative* material that served as a resource for developing an in-depth understanding of the lived experiences of males with an eating disorder. However, in undertaking such a task, the attitude, as researcher, was still one of “doing one’s best under the circumstances, knowing all the while that other possibilities, other interpretations, other ways of explaining things [were] possible” (Clandinin & Connelly, 2000, p.31).

Overview

Stigma toward male eating disorders continues to be pervasive in industrialized and scientific society. At many levels, bias exists against the identification and treatment of males who have an eating disorder. Unlike the predominance of literature allocated to females, the issue – as it relates to males – continues to be either shrouded in secrecy or nebulous at best.

Although men and women who present for treatment for disordered eating show many similarities, literature providing an in-depth understanding of the varied *influences* specific in the aetiology of the disorder in males remains limited, if not null. As such, a steadfast attitude – one that underscores male eating disorders as nothing more than an aberration – continues to reign among a myriad of observers and professionals.

But despite these woes – and notwithstanding a tepid response in the treatment of such males – the aura of male eating disorders endures. It does so, in part, because of individuals like Gary and Adam, industrious souls whose stories have confounded these oft-popular stereotypes. At a time when others declaimed its severity – let alone existence – Gary and Adam issued gentle reproofs. Their traumatic circumstances, undoubtedly, serve as a graphic reminder that males, irrespective of background and lifestyle, are not impervious to societal and familial pressures to look and be perfect.

Conclusions

Having been faced with such overwhelming indifference, both Gary and Adam are marked by an uneasy restlessness in their attempt to derive meaning from events that are, by their own accounts, largely incommunicable. Their stories, however unique and inspirational, are often disturbing and complex to the point of inscrutability. Says Adam, “I don’t think the majority of people will *ever* comprehend what it’s like to have an eating disorder. I can’t really expect them to when I can’t even fathom it myself [most of the time].” Imposing this sense of understanding has been just as tiresome to Gary, who, despite years past, still proclaims difficulty in procuring meaning from his bulimic struggles. Aside from the issue of control, he tacitly acknowledges that he is often at a loss for words, unable to clearly explicate to others the reasoning behind the maintenance of his disorder. “Looking back, I’m not really sure why I did what I did. I just tried to cope the best way I knew how.”

Yet, despite all this uncertainty, both are tolerably content in the possibility of never fully understanding the disorder that has afflicted each of them so tragically. Though their histories, born of misfortune and contempt, continue to be poignant

reminders of what they have endured, they have not been scripts for which each has continued to live their respective lives. Memories of their harrowing past are, for the most part, blessedly distant. Says Gary of this antithesis, “I made a conscious decision not to let my past dictate the person I wanted to be [in the future]. Unlike before, I now understand that you need to feel good about yourself regardless of what you look like on the outside. Happiness comes from within.”

Aside from a shared affinity for honesty, both have a strong predilection for helping others acquire insight into their disorders, as trying as this has sometimes been. “It’s difficult to understand and perhaps even more difficult to explain,” offers Adam. “But that doesn’t mean that [the topic] should be ignored or considered any less important. Others *need* to learn that males do, in fact, have [eating disorders] and that they are serious.”

Familial Relations

In recent past, the role of the family has garnered much attention in eating disorder literature. Research (Stein, 1995) has consistently documented that children’s weight, shape and eating habits are often unduly influenced and affected by parental attitudes and behaviours. Holstein and colleagues (cited in MacBrayer et al., 2001) reported specific learning experiences, such as family modelling, can lead some individuals to form unrealistic expectations that certain behaviours (i.e., restrictive dieting) will lead to certain outcomes (i.e., thinness). These expectancies, in turn, may influence the development of eating disorder symptoms.

Family patterns may contribute to an overemphasis on weight and dieting, especially if one is to consider the salient role the family has in shaping adolescent

values. Recent findings indicate parents who are often absent, uninterested, demanding or critical (Fairburn, 1994) may lay the groundwork for the later emergence of bulimia and other disorders in their children. Cooper (1995), for example, identified weight and appearance-related concerns to be prominent within families of those with anorexia nervosa, while parental indifference, absenteeism and lack of care were most pronounced in families of those with bulimia nervosa.

Many observational studies have revealed that male bulimics tend to be angrily submissive in response to the vitriolic and neglectful parenting they often receive (Vandereycken, 1995). Conversely, parents of male anorectics tend to be over-involved with and over-protective of their sons (Fichter & Daser, 1987). Mothers, for instance, who tend to display a preoccupation with their children's weight and shape often attempt to rectify this concern by limiting their children's daily food intake (Stein, 1995).

Without hesitation, Adam briskly denounces a single instance as precipitating his eating disorder. If anything, he attributes a multitude of disconcerting events as culminating in its onset. Aside from impossibly lofty parental and sibling expectations, childhood concerns relating to food and weight gain burdened him. "Food defined our family. Everything seemed to revolve around it in some way or another. It was quite sad, actually. Great lengths were taken to ensure that both my sister and I did not become *fat*."

Naturally, over time, Adam began to utilize food as a means of expressing the anger he harboured. Because food embodied an anvil of expectations, he wittingly began to show his resistance by not eating what others expected him to eat. Moreover, he would use food to rebel against and rebut those arrogant words that had been laid upon

him by others. “It was exciting and dramatic. I turned to food as a way of controlling the external world.” His mind, however, eventually became his own worst, mortal enemy: “I came to connect my emotional state of mind with weight. Every feeling quickly became associated to food in some way.” The voice within – taunting him daily to lose weight – was ceaseless. Even the smallest and healthiest of foods imbued him with a paralysing fear of becoming fat.

Studies of hereditary influences have revealed that eating disorders also tend to aggregate in families (Andreasen & Black, 1995). In fact, there exists an increased incidence for siblings of male anorexics to be afflicted with the same disorder (Andersen & Mickalide, 1983). Vandereycken (1995) later expanded upon this finding, suggesting siblings of eating disordered patients *in general* show an increased likelihood of developing eating and weight problems themselves. Sadly, for both Adam and Gary, such weight-related concerns have not been isolated instances. Just as Adam’s sister continues to indulge in strict dieting and enthuse about “becoming thinner,” a few of Gary’s siblings have also similarly expressed an intense preoccupation with their weight and shape in recent past.

Perfectionism

The relevance of perfectionism in eating disorders has been extensively documented, both in clinical reports and in empirical research (McLaren, Gauvin, & White, 2001). Not only do disordered eating individuals appear to display higher levels of perfectionism (Davis, 1997), the trait, surprisingly, also appears to persist even after weight restoration and recovery (Bastiani, Rao, Weltzin, & Kaye, 1995).

More recent studies, however, have emphasized the important role of both neuroticism and perfectionism in eating disorders. These traits are believed to be very relevant to understanding how physical attractiveness comes to play a part in the aetiology of disordered eating (Blatt, 1995). More often than not, in an attempt to achieve those goals that will continue to validate their self-esteem, neurotically perfectionistic individuals will tend to set themselves excessively high, and often unattainable, standards. This will continue to be no less true where physical attractiveness is perceived to be the main source of self-worth. However, perfectionism, in isolation, does not appear to be a risk factor for eating disorders. According to Davis, Claridge, and Fox (2000), “problems are more likely to arise when high personal strivings are combined with a tendency to be anxious and hypercritical” (p. 72).

For years, Adam laboured under the stress to become better. Pressures – implicit or not – from his parents to be perfect were keenly felt. He was compelled to succeed at all costs; he strove for *and* demanded perfection from himself.

For me, perfection was being the perfect anorectic, the perfect employee, the perfect student and the perfect family member – all at the same time. I wanted nothing more than to die [even] at perfection. As I saw it, if I wasn't perfect, I had failed, and in those times of failure, I wanted to self-destruct. [Having] an eating disorder seemed like a very appropriate way of doing that. It was either all or nothing.

Gary, like Adam, also expressed a strong inclination to be perfect. He, however, depended upon this recognition and approval to enhance his corroded self-esteem. “I equated status with happiness. Being perfect meant being a better person. I wanted for others to see me as perfect. But, in order to have that, I realized I had to be the best in *everything* [I did]...I couldn't fail.” Tragically, as his pursuance for perfection deepened, so, too, did his penchant for self-loathing.

For years, he immersed himself in weightlifting with terrifying vigour, only to become crestfallen when he did not achieve his ideal shape. At the time, though, he did not see this quest as impractical; he, instead, saw himself as “defective” and fundamentally flawed. “What did it say about *me* when I wasn’t able to look like that, [yet] others around me could? I was obviously not trying hard enough.” This struggle, however, would resurface years later, paving the way for harsher self-criticism and feelings of helplessness. Determined to put an end to his incremental bingeing tendencies, he grew increasingly dispirited at his lack of success. “I tried my best to stop but I landed up doing it anyway. Over time, I just began to feel worse about myself.”

This view, unfortunately, is pervasive among eating disordered individuals. Many will immediately speculate that their inability to stop such noxious behaviours is due to a character or personality flaw (Johnston, 1996). Regrettably, this view is also “supported by well-meaning friends, family, and professionals who suggest that they ‘just stop doing it’: stop starving themselves, stop bingeing and purging, stop eating compulsively, stop gaining weight” (p.20).

Aside from displaying perfectionist tendencies, research has also consistently argued that disordered eating individuals tend to be raised in families that are highly achievement oriented (Andersen & Mickalide, 1983; Andreasen & Black, 1995). Many of these individuals, it seems, are reported to be extremely sensitive, often affecting excessive concern and regret in not being able to fulfill, or maintain, parental or external expectations (Sterling & Segal, 1985). It is perhaps because of this perfectionism, along with low morale, “that dieting and weight loss become significant as means of enhancing

the often weak sense of control these people feel they have over their lives” (Cooper, 1995, p. 201).

Adam, for instance, found himself hopelessly mired in a continual struggle to lose weight and appear more attractive while attempting to pacify his parents’ demands to eat regularly and conform to expected standards. Torn between appeasing others and his inner self, Adam eventually saw his eating disorder as being able to offset these conflicting demands. In the hope of lessening the guilt and the numerous, tired beliefs that he was deserving to suffer, he set out to assert control over his life. Unlike his past, he ultimately came to determine *when* and *how much* pain he would endure. Such a decision, he recalls, was empowering: “I knew that no one could ever hurt me [again].”

Mindful of the disastrous effects his death would have upon his family, he took comfort in knowing his eating disorder would be the “closest” he would ever come to dying without ever doing so. In his mind, this was a generous compromise; others, however, did not see it as such. Over time, though, this explicit pattern of behaviour became more commonplace. In those very rare instances whereby he would oblige his family’s requests to eat, he would do so, only to purge almost immediately after. By doing so, he would, once again, placate to his family’s wishes while mollifying his own. “Ironically, the same thing that paved the way for the start of my eating disorder is the same thing that is now grasping onto me to get out.”

As time passed, though, he unwillingly found himself encumbered by a more pressing concern. “After a while, people just assumed you never ate. Since the *expectation* was that you didn’t, you tried hard not to.” For Adam, the possibility of having others bear witness to him eating elicited insurmountable panic. By engaging in

this act privately, though, he believed there would be less opportunity for others to brand him as undisciplined or “hypocritical” for eating when he vehemently claimed not to. But nothing, he insists, was more unsettling than to have others falsely perceive he was “getting better” or becoming healthier when, in fact, he was not even remotely close.

Gary, ever remorseful, voiced a strikingly different explanation for the secrecy behind his behaviours: “Others always saw me as successful. I didn’t want them to see the worst in me. I really didn’t want to disappoint them...that would have made me [felt] even worse.” However, even in isolation, he continued to feel alienated and different from others. Such secrecy, however, is representative among the male gender, irrespective of context or condition (Andersen, 1999). Males, in general, are far more inclined to repudiate their worries and internalize their self-criticism rather than risk being perceived as *less* masculine (Pope et al., 2000). Unfortunately, though, since “these men carry a secret that they’re uncomfortable sharing even with their closest loved ones, their self-doubts can become almost toxic, insidiously eating away at their self-esteem and self-confidence” (p. 5).

Hesitant to express his emotions for fear they would be perceived as “excessive,” Adam chose, instead, to shut them down completely. Gary, understandably, opted to do the same. He remained unwavering in his conviction, even in those instances when others were quick to denigrate this silence. Throughout his life, many of his innermost thoughts and feelings had either been dismissed or, more distressing, ignored entirely: “I never really felt like I had my emotional needs met. [There were times] I believed that nothing I said or did was taken seriously.” It was jarring, he concedes, to envision a life where he had complete ownership of his feelings. More disconcerting, perhaps, were

those frequent instances in which he was unjustly labelled “hyper-active,” when, in fact, he was just “extremely angry” and “resentful” for the years of verbal and physical abuse he had endured as a child.

Unable to clearly differentiate and communicate these feelings and needs from those of others, his eating disorder provided him with the “voice” to express them. He was, in effect, railing against others’ beliefs that he was fine. “Going to the gym and becoming extremely physically fit turned out to be more than it should have been. It became an obsession because of how I felt about myself growing up and what I had been through. I needed to show that [to others] in some way.”

Associated Behaviours

Amid the clutter and chaos of disordered eating, there exists a sense of serenity. For Adam, a self-proclaimed “creature of habit,” his anorexia and unrestrained use of alcohol and designer drugs provided “a big distraction” from having to face an unpredictable future. Gary, not surprisingly, echoed a similar sentiment. In times of strife and immense confusion, he frequently found himself reverting to old habits and behaviours – specifically those in which he felt most comfortable and empowered. His eating disorder, he openly concedes, served that purpose. It was, he offers, “a total escape” from the perils of everyday life. Over time, his increasing bent for marijuana helped to numb the unpleasantness he associated with eating. This dependency, however, eventually culminated into a full-blown addiction. But these drugs, he readily insists, helped to calm an otherwise morbid plight: “It just seemed to make things a little easier to deal with. It was a distraction, even if it was only temporary.”

Such ruinous behaviours, however, are not considered atypical among afflicted individuals, for eating disorders are rarely diagnosed in solitary (Andersen, 1995). Not only do eating disordered males have an increased likelihood for alcohol and drug related conditions, they also report to maintain a higher incidence of obsessive tendencies, which, in turn, may predispose them to eating disorders (Andersen, 1995; Carlat & Camargo, 1991; Pope et al., 2000; Schneider & Agras, 1987). Clinical lore routinely suggests that engaging in these destructive tendencies often represent an attempt by the afflicted individual to prolong childhood and avoid the responsibilities of adulthood (Andreasen & Black, 1995). Tragically, among these males, suicidal ideation tends to also be pronounced (Andersen, 1999). Though Adam often spoke longingly of death, he was, by his own admission, much too deferential to kill himself. Extremely bothered knowing that such an act would result in unnecessary pain for others, he, instead, turned his contempt and resentment inward. Gary, in thoughts of his own mortality, affected a similar concern: “I could *not* have hurt my family in that way.”

Cultural Images

According to Pope and colleagues (2000), male eating disorders are believed to be “created by biological and psychological forces that combine with modern society’s and the media’s powerful and unrealistic images emphasizing an ever-more-muscular, ever-more-fit, and often-unattainable male body ideal” (p. xv). In our culture, the media continues to overemphasize the popular ideals of physical strength, force, aggressiveness, competitiveness and independence in males. Though some of these traits are unquestionably desirable, others may prove to be problematic (Kearney-Cooke & Steichen-Asch, 1990). Surprisingly, though, the authors report that males who develop

disordered eating behaviours generally do *not* conform to these aforementioned cultural expectations for masculinity. Instead, they tend to be characteristically more passive, dependent and non-athletic, traits, which ultimately, may contribute to increased emotional distress and heightened levels of self-deprecation.

The internalization of idealistic, media-constructed images seem to play an integral part in the development of body dissatisfaction and eating disorders in males (Cusumano & Thompson, 2001). Though increased exposure tends to have a resonating impact on males, even *brief* exposure to media images can have a detrimental effect upon the way men perceive their bodies (Leit et al., 2002). Such images, unfortunately, often falsely link physical appearance to social, financial and sexual success. Males need to learn that “they *don’t* have to buy into the media images that they see, and that it’s okay for them to look ordinary rather than to pursue a forever unattainable ideal” (Pope et al., 2000, p. 240). Brownell (cited in Wilfley and Rodin, 1995) noted that the search for the perfect body is often spurred by two beliefs:

First is that the body is infinitely malleable and that with the right diet, exercise program and personal effort, an individual can achieve the aesthetic ideal. Second, once the ideal is achieved, there will be considerable rewards, such as career advancement, wealth, happiness and interpersonal attraction. (p. 80)

In the depths of his internal despair, Adam unceremoniously found social pressure via health magazines and television. Promises to “look better” and “feel better” left him gamely trying to achieve such results, but often to no avail. “I have many triggers from health magazines. They are, and continue to be, the most disturbing thing in the world to me.” Similarly, as Gary’s obsession with “being noticed” and “looking good” grew, so, too, did his dependence upon the media for reinforcement. The media, he recalls, quickly became a source of both admiration and excess. Magazines and television engrained the

message that perfection was, in fact, attainable. Nothing, he came to innocently believe, was unrealistic – just “challenging.”

Starvation

In an attempt to expedite weight loss, it is not uncommon for disordered eating persons to develop an intense interest in physical exercise and extreme dieting. Adam’s ability to deprive himself of sustenance, for example, was often considered, by many, to be nothing short of miraculous. He took great pride in being able to resist those foods he had an immense fondness for. More importantly, maintaining this discipline required determination and fortitude, something for which he felt he never possessed growing up. “It was powerful knowing I could do what many others could not. I felt better about myself as a result.” Although some openly marvelled at his tenacity – it was extremely difficult to diet, much less abstain from food altogether – others, he says, were clearly reviled at the prospect. Over time, however, his abstinence hardened into a pattern, permeating him with a newfound optimism. “When I fasted, I tended to feel *higher* classed. I always dressed nicer, most often in designer clothes, but when I binged and purged, I felt dirty. I would put less effort into my appearance. I considered myself to be very *low* class – almost scum of the earth.” Internalizing such values, however, is not seen to be uncommon among disordered eating persons because social class has been strongly linked to weight concern (Ogden & Thomas, 1999).

Despite eliciting concern from others over their dramatic weight loss, many disordered eating individuals will unfailingly insist that they are of normal weight, even going so far as to profess an adamant need to lose additional weight. Anorexics, in particular, tend to derive pleasure from their profound weight loss, often expressing a

strong desire to appear emaciated (Andreasen & Black, 1995). Chronic dieting, it is argued, often represents an attempt for eating disordered individuals to offset the feelings of worthlessness, inadequacy and insecurity they often experience (Ussery & Prentice-Dunn, 1992). Unfortunately, though, the body cannot be shaped at will. Biological and genetic factors assume a significant role in the changing of body weight and shape (Wilfley & Rodin, 1995).

Over the years, Adam's obsessive, visceral need to become thinner trumped everything, including remaining healthy. Though not as frequent as years past, he does readily admit, however, the struggle to feel "empty" and "clean" still weighs on him. On occasion, he will find himself unintentionally touting, and comparing himself to, the physical appearances of those around him, albeit in the hospital or out in public. Treatment, he readily concedes, has not entirely diminished his competitive fiery. There still exists a natural inclination to "test the limits" and lose more weight, but not if it comes, once again, at the expense of failing: "What if I'm not able to get back [down] to my lowest weight?"

Alarmingly, his frequent – and often extended – absences from eating did very little to calm the rampant anxiety that typically plagued him. Instead, he woefully found such starvation to hinder him, often leaving him feeling extremely confused and increasingly frustrated. "I managed to trick myself into thinking that I was happier when I really wasn't. I just couldn't understand how despite being at my lowest weight – looking very sick and not having eaten in five days, or so – I still did not feel any better about myself ... maybe it was because I knew I would eventually binge again." Almost always, though, these feelings were exacerbated further by a penchant to binge on foods

he normally did not permit himself to eat: “The act of having to eat was repulsive to begin with, but to binge on unhealthy foods only made things worse.”

Research routinely suggests bingeing often represents an attempt to bring about relief and distract one’s preoccupation with stress (Kinzel et al., 1997; Ussery & Prentice-Dunn, 1992). Bemis (cited in Sterling & Segal, 1985) noted disordered eating behaviours manifest “in response to new situations for which existing skills seem inadequate” (p. 564). Thus, like his female counterpart, the male’s eating disordered behaviour may be thought of as an attempt to compensate for any subjectively felt shortcomings.

As increasingly difficult as it was for Adam to refrain from eating, his insufferable starvation would always give way to intermittent bingeing. It was during these episodes, he recalls, that the feeling of losing control was irrepressible, only to later be displaced by a pronounced feeling of shame. “Unlike bingeing, purging could be justified. If I didn’t fix that mistake [of bingeing], which was always done out of control, I would have been weak. I had the power to control the outcome.” But purging, he soon discovered, did not rid his body entirely of these extra, unwanted calories. In the hopes of lessening this “double” shame, he, instead, began to embrace his disorder more fervently than ever.

Social stressors

Although normally precipitated by restrictive dieting, the onset of disordered eating may also occur as a result of a social disappointment or a major life-changing event (Andersen & Mickalide, 1983). Stressful life events have been found to contribute to the development of both anorexia nervosa and bulimia nervosa in males (Cooper, 1995). Kinzl and colleagues (1997), for example, identified a strong correlation between

disordered eating behaviour and disruptive familial relationships, particularly in connection with abusive experiences.

It would seem that poor or absent parental role models, disrupted family relationships, and a family history of psychiatric illness confer a psychological vulnerability – whether by inheritance or a malign environmental effect – which at a later date for as yet unknown reasons manifests itself as an eating disorder in some individuals when they are subjected to a major life event that they are unable to master.” (Sharp et al., 1994, p. 132)

Having been raised in a home marred by alcoholism and abuse, Gary learned quickly that words, or more specifically, the conveying of emotions, had enduring repercussions. “I grew up very scared. I was fearful that anything I said or did [would result] in getting hurt or hit.” In the end, this perpetual violence had shattered his self-esteem and confidence, requiring him to often seek reassurance for the simplest of tasks. In the aftermath of this ordeal, his life was plagued by a fear of abandonment and rejection.

The unexpected passing of his father years later coupled with a devastating lower back injury would catapult his bulimic tendencies and depressive mood swings. Though he recalls his relationship with his father to be acrimonious, his death still imbued him with a sense of guilt: “It should have been harder on me [than it was]. I had the tendency to beat myself up over that.” Adam, however, was suffused with guilt for more personal reasons. “Placing my infant son up for adoption was very difficult. I knew my girlfriend wanted to keep him and I still pressured her into giving him up. After that, I felt I *deserved* the punishment of starving myself.” His self-destructive tendencies were later compounded by the lifestyle he devoutly embraced: “You can’t be a chubby gay guy. Coming out of the closet only reinforced those concerns [I initially had] about body image.”

Eating disorders typically occur within a culture or subculture that reveres thinness and physical appearance. In comparison to heterosexual men, homosexual men tend to report greater body dissatisfaction, frequent dieting and display more attitudes and behaviours commonly associated with disordered eating (French et al., 1996; Siever, 1994). Sadly, in response to the realization that homosexual feelings are not socially endorsed, many of these males may adopt bulimic behaviours as a means of coping (Carlat & Camargo, 1991). Conversely, many heterosexual males may become emotionally disconnected from what Pope and colleagues (2000) commonly refer to as their *body consciousness*. According to these authors, “these men may deny even to themselves that appearance matters to them, while in their psyches they are troubled by these conscious or semiconscious preoccupations” (p. 218).

French, Story, Ramafedi, Resnick, and Blum (1996) offer the explanation of significant numbers of gay men developing eating disorders because they typically identify with female rather than male role models. Hasan and Tibbetts (cited in Herzog et al., 1990) noted that “male anorexic patients exhibited a notable lack of assertive masculinity or identification with other males” and an apparent fear of “manhood, with particular reference to the heterosexual role” (p. 43). Such an observation is none more apparent than within Western gay cultures where an exaggerated emphasis on youthfulness, slenderness and attractiveness tends to predominate (Williamson, 1999).

The development of eating disorders in males has also been reported to be largely attributable to sport endeavours (Andersen, 1995). Many, in fact, are apt to incessantly diet following a sports-related injury to counteract any weight gain that might have been accrued due to inactivity (Andersen, 1990b). However, research suggests it is far more

likely that these males engage in strict dieting to compensate for having been overweight and teased as a child (Andersen & Holman, 1997; Cooper, 1995; Sharp et al., 1994). Not surprisingly, weight comments, even in jest, may precipitate a crisis among overly sensitive males. Herzog and colleagues (2000) identified the prognosis for recovery from disordered eating to be significantly poorer in those instances where young people were subjected to playful scrutiny and criticism from other family members.

Like Adam, Gary's disinclination to be "average" reinforced his baleful behaviours. Having been overweight and ruthlessly teased as a child, he, too, developed an intense fixation on exercise to enhance his low self-image. Aside from the stupendous achievements, bodybuilding infused him with a sense of pride and acceptance; he relished the feelings of "accomplishment" and "power" it afforded him. There was, he concedes, a certain cachet attached to being "the best" in his sport.

More troublesome, though, were those frequent instances in which he silently embraced the repercussions of disordered eating *more* than a life of monotony and mediocrity. There was, he insists, a growing need to hide his weaknesses and not allow himself to appear "vulnerable" and human. Although loved ones ached for him, he had made a concerted effort to never again feel weak, neglected or humiliated. For Gary, to admit to this fear, and to ask for help, would have been to admit failure. The stigma attached to this disorder only complicated matters. "I felt very ashamed and abnormal. I knew that there were a lot of others who suffered with [bulimia], but they were women. Being a male just seemed to make it that much more difficult [to admit to]."

Stigma

In comparison to their female counterparts, males are less likely to be diagnosed with eating disorders by physicians. While a few continue to profess ignorance, many health care professionals remain uninformed about the existence of eating disorders in males (Andersen, 1999; O’Dea & Abraham, 2002). These men, in turn, become extremely reluctant to seek professional care for an illness that has been stigmatized as afflicting only women (Carlat & Camargo, 1991; O’Dea & Abraham, 2002). As Pope and colleagues (2000) identified,

Not only does society forbid men to talk about their feelings of vulnerability and inadequacy, but it also indoctrinates them with the idea that only women are supposed to worry about their looks. Men, according to our society, do not – and should not – worry about their appearance or the shape of their bodies. A man who does focus on their appearance is often seen as vain, narcissistic, or “feminine.” (p. 17)

Recent research, however, indicates males are just as unhappy with their physical appearance, often perceiving themselves as looking different or worse than they really do (Pope et al., 2000). Unfortunately, those males who suspect they may have an eating disorder are often hesitant to allude to this diagnostic possibility for fear that they will be unfairly stigmatized, either from society or from their peers. As Andersen (1999) surprisingly discovered,

[I have] never met a male with an eating disorder who was proud of his clinical condition; these males usually present with a posture of defensiveness. One HIV-positive gay man with bulimia said that his eating disorder was more stigmatizing to him than his HIV-positive status. (p. 208)

But more distressing, perhaps, is the stigma that many of these males endure from eating disordered females, who view them as either intruders on their illness or transference objects, and by health maintenance organizations, who refuse to pay for treatment because of the underlying belief that males are immune from such an illness

(Andersen, 1999). Because of such ignominy, most men, alarmingly, do *not* even realize that treatment – let alone effective treatment – exists for their disordered eating (Pope et al., 2000).

Discussion

Recovery from disordered eating is a perennial and pain-filled process. If individuals are to truly prosper, then changes – however numerous – need to be implemented and scrupulously adhered to. Such success, according to Johnston (1996), is largely dependent upon the recovering individual learning to reframe their self-image, adopting the understanding that regardless of what others may say, they are not “damaged goods” and that their eating disorder is not “evidence that [they are] a faulty human being in desperate need of repair” (p.19). The development of new skills also becomes integral for these afflicted individuals, particularly when searching for more efficient means to cope with the stressors that may have precipitated the onset of, and now reinforce, their disorder. Only after the formation of these new skills, she says, will individuals be able to employ them effectively to replace the function their disorder once served them and live a life free from food obsession.

By his own accord, Gary’s eating disorder made amends for the embarrassment he endured throughout his childhood and early adolescence. He openly espoused the personal autonomy and self-control bequeathed to him as a result of it. It was, in his view, his greatest and only achievement. Much of his exalted status had been based on bodybuilding and his dietary restraint. Had it not been for his bulimia, he concedes the fearful intensity that helped him achieve notoriety in bodybuilding circles would not have been instilled in him. By controlling his food intake, other facets of his personality were

soon ameliorated. Aside from giving rise to an already ever increasing profile, an enhanced sense of self-worth and self-confidence permeated him. His eating disorder, for all that it was worth, enabled him to become “a different person,” someone he had always desperately wanted to be, but never thought he could be. “For the first time [in my life], I liked who I was. It was such a relief. I didn’t have the urge to go hide and feel ashamed.”

Today, however, he forcefully deflects the often accepted, but inaccurate, wisdom that eating disorders are not meaningful. If anything, he feels as if he has proved resistant to all claims to the contrary. Through periods of grave danger and uncertainty, he remained steadfast and resilient. It is partially for these reasons, he asserts, that he was able to “conquer” the disorder that bedevilled him for over a year. “Unfortunately, in the end, the alcohol and the drugs were killing me faster [than my eating disorder]. They proved to be more dangerous. I had to experience something more dramatic before I finally decided to ask for help.”

Conjointly, even though Adam has grown accustomed to the ill-fated comments frequently directed at him, he continues, with steely resolve and unbridled energy, to explain the intricate details of his eating disorder. He, like Gary, no longer relishes the need to conceal his “true self” and quiet the “voice” that eerily tormented him for so many years. Nor does he, predictably, wish to bleat about the rigors of his disorder. Instead, he is much more prone to acknowledge, and endorse, his eating disorder as the simple and necessary coping mechanism that it is. He does so, he says, in the hope of having others learn that, for him, food is merely a means by which he manages with more grievous problems. “Most people don’t understand why you can’t just eat. They’ll often

say, ‘what’s wrong with you?’ But to me, it’s the most natural thing. That’s what makes me happy. Why would you want to give up something that makes you happy?”

Rather than viewing their eating disorder as a hindrance to their well-being, sufferers need to learn how their disordered behaviours have contributed to their survival. In times of crisis, they must be reminded how their eating disorders have reliably assisted them to deal with the myriad of conflicts and feelings they’ve encountered. For many, eating disorders are utilized as a helpful means to cope with the emotional distress of being different or feeling misunderstood or unaccepted (Johnston, 1996). These individuals, she suggests, “need to consider the possibility that the development of disordered eating patterns may not necessarily have been such a poor choice, given the limited options, resources, or coping skills [they] had available to [them] during stressful periods” (p.19). More importantly, recovering individuals need to learn how to embrace – not denounce – resistance, for any behaviour that tends to impede the recovery process often has meaning and a purpose that can be of essential value.

Recovery from disordered eating begins with the understanding that the disordered eating behaviour served you when your goal was survival. This understanding is then followed by the development of new skills that will enable you not to simply survive, but to get what you want out of life, to thrive. Survival is no longer the only goal. The goal becomes one that includes a life that is rich and fulfilling. It is a gradual, step-by-step process that calls for letting go of judgment (“there is something wrong with me”), the development of some important life skills, and learning to trust that inner voice that will tell you when you are ready. (Johnston, 1996, pp. 21-22)

Implications for Counselling

When considering the increased prevalence of eating disorders over the last decade, the necessity for early recognition and intervention by varied professionals becomes all the more essential. Through the years, treatments have become available in an effort to counter this increased flux; sadly, despite an increasing public awareness to the recognition of the disorder, prevention strategies and treatment programs continue to cater almost exclusively to females. Consequently, this may lead for some males to doubt the severity of their illness and their need for treatment. Counsellors, then, must implement (and, on occasion, refine) strategies that will assist males in facing and overcoming this debilitating condition.

Though many influences exist in the aetiology of male eating disturbances, the role of family continues to be one of the most salient and, as such, needs to be promptly addressed. Tragically, the profound effect that eating disorders have upon the livelihood of family members is often overlooked and, at times, dismissed from treatment protocol. In such an occurrence, the implications may be long-standing and severe. Professional treatment with an emphasis upon the family may be extremely helpful, particularly when the eating behaviours have been perpetuated by disruptive or neglectful family interactions. Educating family members to understand the impact of the disorder on their lives, as well as that on their loved ones, and assisting them to learn new strategies for coping with problems can be decidedly beneficial. In select instances, “help might take the form of working with parents to lessen the attention and criticism directed at their children’s body weight and shape” (Stein, 1995, p. 190). Family therapy has to be viewed as an indispensable component in the treatment of eating disorders, irrespective of gender.

As a means of maximizing effectiveness, treatment programs and support groups need to be implemented that will not only assist males in learning more about eating disorders but also becoming aware of the resources immediately available to them. Because disordered eating is traditionally pervasive in females, many males will be disinclined to seek out counselling, often even denying any physical and mental problems; conjointly, for those who do, many of them may be reticent to talk. Affective expression, for the most part, will be shunned as a result of the increased discomfort and anxiety it creates. But as Pope, Phillips, and Olivardia (2000) iterate, such silence is often paradoxical. “On the one hand, everywhere we look we’re surrounded with messages about the importance of appearance. But if a man gets up the courage to voice his concerns about appearance, he may be criticized for doing so” (p. 228).

Group counselling, however, can be an effective paradigm for this change, particularly when other males, who share similar concerns, serve as models and reinforcement for new behaviours. Males may come to realize that they are not, in fact, abnormal or different in their problems or concerns, after all.

The starting place for healing this crisis of male body obsession – a crisis that extends across race, nationality, class, and sexual orientation – is to help men understand that they are not alone with these feelings, that millions of others share the same concerns and tribulations. It is time to help men appreciate the underlying social forces that contribute to their negative feelings about their bodies. Men must learn to acknowledge and talk about these feelings, to overcome the “feeling and talking taboo” that society has long imposed on them (Pope et al., 2000, p.26).

By providing a safe setting to experiment with change, males will be able to gauge the impact of their actions on others and receive honest and helpful feedback. The group process, in effect, may also serve as incitement for those few who invariably recognize a personal want or need for individual counselling (Gladding, 2000). In addition to

promoting more cohesiveness among males, opportunities arise for counsellors to normalize and validate any fears and misgivings maintained by group members. It is crucial to assist males in developing constructive strategies for confronting, and dealing with, conventional cultural expectations for masculinity and to increase personal awareness of changing roles.

Paramount, however, is the establishment of trust, a phenomenon that, in turn, will foster greater self-disclosure. A male counsellor, for example, who is sensitive to and utilizes appropriate self-disclosure, will ultimately promote the sharing process and, in the process, facilitate the functioning of the group. In such a set-up, group members will also have the opportunity to observe, learn and mirror effective male interaction. The presence of a male counsellor will undoubtedly serve as reinforcement for those males who wish to express themselves directly and honestly, while retaining, as Adam eloquently acknowledges, “what’s left of our maleness.” It is extremely important, however, that these groups, as effective as they may prove, be seen as *complementary* to, and not a substitute for, other mental health services.

Essential also is the necessity for health care or counselling professionals to work collaboratively with educators and administrators to advocate for the awareness of male eating disorders. Prevention programs aimed specifically at promoting healthy development will be invaluable, particularly if initially addressed during the primary years. It is not, however, recommended that the physiological consequences of eating disorders be simply tended to. Should prevention efforts rely solely on educating the public about recognizing the signs and symptoms of eating disorders, such attempts will likely be unsuccessful, and may even unwittingly encourage disordered eating (Andersen,

1999). As such, special attention must be considered to the variety of physical, emotional, social and interpersonal issues that often contribute to the development of eating disorders in males. Effective programming must address (though not necessarily be restricted to): the furtherance and development of self-esteem in males; demonstrating respect for alternative lifestyles; educating males about the baleful effects of dieting and bullying; developing a value system based on internal standards; encouraging open communication; and, modifying societal norms, including confronting the media's artificial image standards.

[I]n our society, it is time to create widespread awareness about body-appearance concerns in men, and allow men to voice these concerns to those who care and love them. We need to expose the societal and cultural forces that are inculcating new unattainable male body standards, and share the stories and voices of scores of men who have become frustrated and ashamed by their failure to meet these standards (Pope et al., 2000, p.26).

Of key importance, however, is for opportunities to be presented for males within these settings to speak in confidence with competent professionals and, when appropriate, receive increased support and specialist help. Tragically, for every boy or young man suffering from a fully developed body image disorder, there are many more displaying *milder* – but still hurtful – symptoms of the same obsessions (Pope et al., 2000).

Finally, and perhaps most importantly, is the need for hospitals, clinics and other treatment facilities to employ more males as accredited helping professionals in the wake of these afflictions. Regrettably, the palpable absence of male counsellors only undermines the attraction for prospective male clients to seek out the appropriate, and often necessary, help for their individual conditions. Additionally, this scarcity only belies the public that eating disorders are exclusively a female disease, in effect further reinforcing this traditional stigma. Because the majority of males are often exceedingly

hesitant to admit to having disordered eating, the presence of a female counsellor may elicit an unwillingness to confer about, or a tendency to minimize, their eating behaviours. Therefore, it is imperative that apposite measures are taken to ensure that male clients are afforded the opportunity to *choose* among mental health counsellors who they feel will not only be sincere with, but also empathic to, their perspective.

If counsellors are to be seen as a valuable catalyst in assisting males to seek out treatment for their eating disorders, males need to accurately deduce that professionals are taking their heart-rending conditions seriously. Eating-disordered males are typically relieved and express an eagerness to be counselled when they feel that clinicians appreciate their concerns (Andersen, 1995). Others, however, are less apt to recognize and validate these struggles. As evidenced within both Gary and Adam's narrations, a few professionals affected disbelief and, alas, even an unwillingness to assist them in their time of need. Parents, teachers, coaches and health professionals frequently fall prey to the illusion that males do *not* agonize over their appearance. "In our society, 'real boys' aren't supposed to worry about such things. Parents don't ask, and boys don't tell" (Pope et al., 2000, p. xiv). Essentially, counsellors must convey a sincere allowance for males to possess these disorders; males' thoughts must be attentively listened to and their feelings, however infrequently expressed, must be respected and never be dismissed. As Adam mournfully recounts:

I was just terrified the doctor wouldn't [believe me]. I made sure that I lost enough weight to qualify myself as an anorexic before I walked into treatment because I wanted to make sure that they couldn't deny it. There would be [calluses] on my hands and cuts on my knuckles and in the back of my throat. I did everything I could [to ensure] that they would take me seriously and believe that I had an eating disorder.

Counsellors must also be cognizant of, and permit for, the inevitability of failure and relapse throughout the treatment process. For Adam, this entails paying closer attention to the “grey area” encapsulated within the diametrically opposite “all-or-none” view. The small steps, for all intents and purposes, need to be acknowledged and continually reinforced. “Success,” Gary astutely offers, “should *not* be seen as the end result. The real [success] lies in making mistakes and then accepting them [as such] so we can learn that we don’t have to be perfect.”

Future Directions

If professionals are to acquire an intricate understanding of the crippling impact of eating disorders on males, it is essential that research, however compendious, be conducted and continually expanded upon. In comparison to the preponderance of literature available on female disordered eating, there currently exists very little research relating to males. It is imperative, then, as researchers, to make certain that male eating disorders are not trivialized. Future investigations targeted specifically at the male gender will undeniably promote awareness of and countervail the underlying belief that such disorders affect only females; in the process, considerably lessening the *secondary* status frequently afforded to males in discussion of these disorders.

In future research and discourse on male eating disorders, it is of interest to identify the repercussions of those males who have presented for disordered eating but, tragically, have never sought out counselling. An exploratory study identifying males’ *rationale* for not acquiring treatment would prove most beneficial, particularly when considering the grievous effects incurred at the expense of its exclusion. Of further interest, however, are the numerous questions that arise in undertaking such a task: of

those males who have been treated for disordered eating, what has prompted them to do so? What types of males are more likely to seek out help for their conditions? Of those males who do not seek out assistance, what would entice them to do so? What are the circumstances under which male eating disorders worsen and how can it be prevented or treated? How severe do males' conditions have to become before they voluntarily seek out treatment? To date, there has been little documented that address these important issues.

Clearly, the impact of disordered eating extends far beyond the principal sufferer. Research investigating the direct or indirect effects on parents and other family members requires extensive and ongoing evaluation. Because problems among family members often arise as a result of disturbed eating behaviour, a closer examination of these troubled family interactions is noteworthy. Often, a family member's resistance to partake in, and patent absence from, counselling will present a myriad of challenges for the sufferer and other family members throughout the recovery process. Thereby, an investigation into the effects, if any, of a family member's opposition to therapy on the prognosis of male eating-disordered clients is also of valuable interest. Naturally, in undertaking such a sensitive issue, queries will surface that may serve useful in future research. These may include: Within the family dynamic, who is more likely to be impacted the greatest? What are the reasons provided by family members for non-participation in treatment? What are the long-term family implications of not seeking out appropriate help? Moreover, very little research has been conducted on the effects of weight-related teasing and criticism by parents on male family members (Schwartz, Phares, Tantleff-Dunn & Thompson, 1999). As a means of understanding eating

disorders, it is paramount to see how the family system perpetuates disordered eating in males in all forms.

Although it remains increasingly beneficial to address sensitive issues of stigma and sexuality in the group process, research outlining *who* administers this treatment is of some interest. The impact of gender-based treatment upon male eating disorders would be advantageous when considering the differential needs that exist between genders in the treatment process. While it appears that patients are “very similar during the most severe phases of illness, the gender differences before illness and the anticipated gender differences in social functioning after improvement should be kept in mind in preparing the patient for a good long-term outcome” (Andersen & Holman, 1997, p. 395).

However, to date, the gender of the counsellor and its significance upon treatment of males has yet to be studied.

Because a resemblance does exist between males and females with eating disorders, it is not then inconceivable for males of varying ages to also be afflicted with these disorders. Future studies may wish to examine the conceptual similarities and differences that exist, if any, between these males. The identification of specific risk factors and how they may implicate in the development and prognosis of male eating disorders across ages have not been elucidated and thus, warrant attention. Additionally, the effects, if any, upon those children of former eating-disordered males have never been investigated (Andersen, 1995).

At many levels, delineating credible research is dependent upon the professionals who work closely with these disorders. Preventive efforts to decrease the occurrence of eating disorders in males will be effective providing professionals and educators

incorporate this issue into curriculum and collaborate to implement counselling programs. Because eating disorders require an integrated approach to understanding, future studies need to be as accommodating to and beneficial for males as they have traditionally been for females. Andersen and Holman (1997) suggest that programs and preventive intervention that have incited awareness to, and have proven effective against, eating disorders in females should also be replicated with males. Long-term studies that utilize a larger sample of males will also provide more concrete data.

Perhaps more importantly, generalist-training opportunities need to be provided to mental health professionals with knowledge about the fundamental causes and contributing factors of disordered eating. Professionals must be competent in their understanding of the existence and presentation of eating disorders in males. Research sensitive to the male gender and sexual orientation requires further assessment, as does the interactive effects of social norms and family influences. Rather than assuming males are susceptible to the same sociocultural and familial factors as females, Andersen (1995) suggests it may be beneficial to explore individual aspects of the aetiology of disturbed eating in males. However, due to the increasingly complexity of these disturbances, it is proposed that future research be directed toward only those specific areas that are feasible (Andersen, 1999).

Epilogue

Though their stories were sometimes laboured, both Gary and Adam remained blithely confident that their experiences would edify those who would take the time to read them. Their anecdotes served as a sobering surprise, each of them gently initiating

awareness to, and providing a *preliminary* understanding of, the threat that eating disorders posed for modern males, albeit physically, socially and even emotionally.

In reality, only Adam successfully sought assistance for his disorder, and he did so, he denounces, “reluctantly.” Sadly, he was much more inclined to die than to obtain help for his condition. If not for his sexuality, he concedes, he would have been extremely reticent to acknowledge his eating disorder. Conjointly, Gary expressed similar reservations. Had it not been for his equally parlous alcohol and drug addiction, his overt fear of being labelled “different” and “unusual” would have prevented him from coming forth for treatment – again.

But perhaps the resonance and potential of these stories was best understood by the heft of silence that was lifted as a result of having been able to speak of these lived experiences. Their sensational stories will serve as a calming influence for other males hampered by the same crippling disorder. They, like Gary and Adam, no longer have to suffer in silence with body image concerns and pithy expectations.

In the future, if research is to truly prosper in advancing male eating disorders beyond its already limited purview, then opportunities for such insights need to be made available. For only through the casting, and trenchant analysis, of stories in narrative form will professionals, families and friends be awakened to the personal misery and “secrecy” that dangerously insinuates itself into the marrow of these afflicted males.

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APPENDIX A: APPLICATION TO ETHICS COMMITTEE

UNIVERSITY OF SASKATCHEWAN ADVISORY COMMITTEE ON ETHICS IN BEHAVIORAL SCIENCE RESEARCH

1. Name of Researcher(s) and Departments(s)

1a. Ryan Ashuk, Master of Education Candidate, Department of Educational
Psychology and Special Education, University of Saskatchewan.

Dr. Walt Pawlovich, Assistant Dean, Student Affairs, College of Education
(Supervisor)

1b. Start Date of Research Study: August, 2003
Completion Date of Research Study: October, 2003

2. Working Title of Study

Narratives of Males With Eating Disorders

3. Abstract

To date, eating disorders have been studied extensively among adolescent and young adult females. Despite recent research indicating a significant percentage of males also display behaviours related to eating disorders, their experiences, for the most part, remain unstudied. Few *qualitative* studies have been completed that focus specifically on a male's experience with anorexia nervosa or bulimia nervosa. Unfortunately, due to the small numbers of males diagnosed with this "female disease," few studies yielding *in-depth* accounts of their lived experiences have also not been completed.

The proposed investigation will explore the stories of two adult males afflicted with disordered eating. Through their narratives, a richer understanding of what it is like to live with this debilitating illness will be provided. For purposes specific to this study, however, depth of understanding will be emphasized as opposed to breadth of understanding. The findings are expected to contribute in ways that will help to inform the practices of counsellors and therapists, as well as add to extant literature.

4. Funding

No funding has been secured for this proposed study.

5. Participants

Recent eating disorder research reports a ratio of one male to every ten females in clinical settings, and two males for every 10 females in community settings. This finding along with the reality that many males usually conceal or deny the disorder makes for the identification of willing participants for this proposed study challenging, but not impossible. Utilizing a convenience sampling technique, the criteria for participant selection will include: (a) males who are at least 18 years of age or older; (b) males who have been medically diagnosed with and treated, or were presently being treated, for Anorexia Nervosa or Bulimia Nervosa; and (c) males who are willing to participate in this study.

Through contacts with the managing director at the BridgePoint Center for Eating Disorders in Mildred, Saskatchewan, I will be able to recruit two males who successfully meet the aforementioned eligibility criteria. In order to ensure anonymity and confidentiality, only the names of those males who have voluntarily expressed an interest in participating in the study will be provided by the director and ultimately, contacted by myself, the researcher. Prospective participants will *not* be unduly influenced and/or coerced into participating. At the time of first contact, participants will be thoroughly informed about the study and their rights as prospective participants. An ethics contract, outlining the purpose of the study, any foreseeable and potential risks and benefits, and emphasizing the confidential and voluntary nature of the study, will be strongly adhered to by both researcher and participant(s). Additionally, should the potential participants be interested in obtaining further information about the study, the names and telephone numbers of the researchers involved will be provided to them.

6. Consent

An ethics contract, complete with consent form, will be provided to each participant upon initial interest. Signing of the contract will indicate that the participant acknowledges that the study and contents of the consent form have been explained to him, that he understands the contents, and that he received a copy of the consent form for his own records. Please see “Ethics Contract With Study Participant” attached.

7. Methods/Procedures

Paradigmatically, this study will function exclusively within a qualitative framework. In this inquiry, data will be collected primarily through active/unstructured interviews (employing guiding questions and probes) and field notes. This in-depth interview series will consist of two to three individual interviews, each interview *not* exceeding 90 minutes in duration.

In the event that a third interview is deemed necessary, the purpose will be to ask questions not covered during the first two interviews, clarify issues raised and explore concerns and commonalities. More importantly, I will utilize this interview as an opportunity to ask the participants to help me make meaning of their experiences. Aside from the interviews, all interpretations, impressions and feelings will be documented in the form of field notes.

These interviews will be used to explore and gather *narrative* material that will serve as a resource for developing a deeper understanding of the lived experiences of males with an eating disorder. All interviews will be audio-taped and then carefully transcribed by an experienced transcriber. In order to ensure accuracy, the researcher will listen to and read all transcripts. Participants will also be afforded the opportunity to revise or withhold any elements of, or the entire, transcript.

8. Storage of Data

In order to ensure that all identifying information will be safeguarded for reasons of anonymity and confidentiality, Dr. Walt Pawlovich will be assuming responsibility for all data storage upon the completion of the study. In accordance with University of Saskatchewan regulations, data will be securely stored for the required five years in a locked facility in the department of Educational Psychology and Special Education.

9. Dissemination of Results

The data collected in this study will be reported in a master's thesis and shared with the faculty of the Department of Educational Psychology and Special Education at the University of Saskatchewan. The results of this study may also be used in subsequent journal publications and conference presentations.

10. Risk or Deception

Any risk associated with this study is minimal. Participation in the proposed study is strictly voluntary and the participants have the right to withdraw at any time. However, since the subject under investigation is sensitive in nature, as researcher, I must be continually attentive to any distress and discomfort that the participant(s) might experience. In the event that involvement in the study evokes disturbing responses, I will endeavour to assist the participant(s) in securing appropriate support including professional counselling services.

11. Confidentiality

Several precautions will be taken to ensure confidentiality and anonymity. In addition to each participant signing an informed consent form, pseudonyms, as chosen by the participants, will be utilized to identify each of them during data collection and analysis. Participants will be invited to check all transcriptions of interview excerpts for accuracy and acceptability.

Furthermore, excerpts of interviews that will appear in the final written thesis will be used with the consent of the participant. All audio tapes, interview transcripts and field notes will be securely stored and safeguarded by my thesis supervisor for a minimum of five years, in accordance with University of Saskatchewan regulations.

12. Data / Transcript Release

Each participant will be afforded the opportunity to access the collected information at any time for the purposes of checking for accuracy and omissions. Following this, participants will be asked to sign a transcript release form (Appendix C), which states that they agree with the accuracy of their stories and perceptions extrapolated by the researcher. Only the parts of the transcriptions relevant to the study from each participant's interviews will be a permanent record of the study.

13. Debriefing

Upon completion of the study, each participant will receive a summary of the research findings and a copy of the thesis if they so wish. In addition, the researcher will utilize this session as an opportunity to provide a list of counsellor names and/or referrals to each participant should they be required.

14. Signatures

Ryan Ashuk – Master's Candidate, Department of Educational Psychology and Special Education

Dr. Walt Pawlovich – Supervisor, Assistant Dean, Student Services, College of Education

Dr. Vicki Schwean – Department Head, Department of Educational
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15. Contact Information

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APPENDIX B: PARTICIPANT CONSENT FORM

Title of Study: Narratives of Males With Eating Disorders

PURPOSE OF THE STUDY:

The purpose of this study is to describe, in an attempt to understand, the lived experiences of two adult males who have been medically diagnosed with and treated, or are presently being treated, for an eating disorder. Of additional interest, however, is the examination of familial and sociocultural influences on disordered eating behaviours in males. A study of the varied influences that render these males “at-risk” will ultimately improve our understanding of the processes specific in the development of the disorder.

METHODOLOGY:

Data collection will include a maximum of three interviews, field notes and transcription.

The study will involve you as follows:

1. Two to three interviews (45-90 minutes) in order to obtain your views on the familial and sociocultural influences that render certain males “at-risk” for the development of eating disorders. A preliminary interview will occur before the commencement of the study at your convenience. All interviews will be audio-taped, transcribed and then stored and safeguarded by Dr. Walt Pawlovich for a minimum of 5 years, in accordance with University of Saskatchewan regulations.
2. As participant, you will be afforded the opportunity to review all transcriptions of your interviews and field notes of our conversations to ensure accuracy. Please note that all data collected from you will fall under your ownership *until* you approve and “sign off” the information to be used for the purpose of my thesis. As researcher, I will contact you via telephone or e-mail to arrange for specific interview times and the most convenient method for transcript/field note reviews. Please be assured that all interview and transcript/field note reviews will be done at your convenience.

Unfortunately, due to the small numbers of males diagnosed with eating disorders, a seemingly languid interest in the topic and inherent methodological problems, studies yielding more definitive conclusions about familial and sociocultural influences on male eating disorders have not been completed. However, by participating in this study, you will have the opportunity to assist in the identification of problematic eating behaviours in men as a response to such external influences. I anticipate that the knowledge and insight gained will be highly beneficial to counsellors, educators and counselling

practice, research and theory. It is also important to note that that this study was reviewed and approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on July 16, 2003.

Please read the following points in regards to your rights as a participant and how your interests will be safeguarded.

1. Your participation in the study is strictly voluntary. There will be no foreseeable risk or deception involved in your participation or non-participation in this study. However, since the subject matter under investigation has the *tendency* to be very sensitive in nature, a list of counsellor names and referrals for the participant(s) will be made available during and/or at the completion of the study.
2. All information collected will be held in strict confidence. Every effort will be made to safeguard your anonymity. Any records or files will refer to you by a pseudonym of your choosing. The results of this study will be published in a thesis and may also be used for publication in scholarly journals or for conference presentations.
3. Only information relevant to the study will be collected. As a participant, you will be advised of any change in the study. More importantly, you are free to withdraw from the study at any time.
4. As a voluntary participant, you own all the information that is collected from you. If at any time you want any or all of the information deleted from the study, it shall be done so immediately by deleting all tape recordings and destroying all notes, transcriptions, etc.
5. You will be asked to read the transcriptions of your interviews and to make any changes to ensure your anonymity and their accuracy. Please note that any direct words, comments and/or quotations from the transcripts you approve of and “sign off” may be used in the thesis.
6. At the completion of the study, all tape recordings and interview transcripts will be safeguarded at the University of Saskatchewan for a duration of five years, in accordance with the guidelines set by the Advisory Committee on Ethics in Behavioural Science Research at the University of Saskatchewan. After that time, all tape recordings will be erased and all interview transcripts will be destroyed. Only the parts of the transcriptions relevant to the study from your interviews will be a permanent record of the study.
7. You will receive a summary of the research findings (Chapter 5 of the thesis) at the end of the study and a copy of the thesis if you so wish.
8. Should any new information arise that may bear on your decision to continue in the study, I will advise you.

9. Any questions or concerns about this study may be directed to Ryan Ashuk (931-7891); my advisor, Dr. Walt Pawlovich, Assistant Dean, Student Affairs, College of Education (966-7672); or the Office of Research Services (966-8576) should you require further information regarding this study. Additional contact information is provided below.

CONSENT:

I have read and understood the above points, and I agree to follow them. I have also received a copy of this contract for my own files.

Study Participant (signature)

Date

printed name

Telephone: _____

E-mail: _____

Dr. Walt Pawlovich
Assistant Dean, Student Affairs
College of Education
University of Saskatchewan
Telephone: (306) 966-7672
E-mail: walt.pawlovich@usask.ca

Date

Ryan Ashuk
Graduate Student
Department of Educational Psychology,
University of Saskatchewan
Telephone: (306) 931-7891
E-mail: rashuk@shaw.ca

Date

APPENDIX C: Transcript Release Form

RESEARCH STUDY: **Narratives of Males With Eating Disorders**

RESEARCHER: Ryan Ashuk

I, _____, have had the opportunity to review the complete transcript of my personal interview in this study, and have also been afforded the opportunity to withdraw any or all of my responses and correct any misrepresentation of data. I acknowledge that the transcript accurately reflects what I said or intended to say in my personal interview with Ryan Ashuk. I hereby authorize the release of this transcript to Ryan Ashuk and Walt Pawlovich to be used in the manner outlined in the ethics contract and consent form. I also have received a copy of this Data/Transcript Release Form for my own records.

Participant's Signature: _____

Participant's Pseudonym: _____

Researcher's Signature: _____

Date: _____

APPENDIX D: INTERVIEW GUIDE

1. Where would you like to begin the story of your eating disorder? Feel free to begin wherever you like, going as far back as you think you need to or starting today if you like.
2. When did you first realize that you might have an eating disorder? Tell me the story of how the disorder has affected your life?
3. What is it like being a male afflicted with an eating disorder? How have others responded to your disorder? What is/was it like to seek out treatment?
4. What sensations, emotions, behaviours, thoughts are associated with your eating disorder?
5. Who are/were the important people in the story of your eating disorder? Who needs to be included in the story?
6. What role does/did your family play throughout your experience? In your opinion, what events/influences might have precipitated the onset of your disorder?
7. What changes have you noticed in your life since obtaining help for your disorder?
8. How does the story of your eating disorder end?