

Exploring Men's Accounts of Understanding and Seeking Help for Problems with Eating

Laura Markham

A thesis submitted in partial fulfilment of the
requirements of the University of East London
for the degree of Doctor of Clinical Psychology.

May 2013

ACKNOWLEDGEMENTS

This research would not have been possible without the generous help, support and encouragement from many others. I would wholeheartedly like to thank the participants for their time and openness in sharing their stories with me. I sincerely hope that I have enabled their voices to be heard. I would also like to thank those at MGEDT for their invaluable help in the process of conducting the research.

I would like to express particular thanks to Martyn Baker and Dr Rachel Bryant-Waugh, for their input and encouragement throughout all stages of the research. The ideas, guidance and feedback that they have both provided have been inspiring and hugely valued.

Thank you to my wonderful friends for helping out in so many different ways. Finally, I would like to express my sincere gratitude to my family for their hearty support, humour and encouragement throughout the doctorate journey.

CONTENTS

1.	ABSTRACT	p. 1
2.	INTRODUCTION	p. 2
	Overview	p. 2
	‘Eating disorders’: Current definitions	p. 2
	Why focus on men with ‘eating disorders’?	p. 4
	Incidence, prevalence and presentation	p. 4
	Incidence and Prevalence.....	p. 5
	Presentation.....	p. 6
	Issues in the development of ‘eating disorders’ in males	p. 6
	Body awareness in boys.....	p. 7
	Athletics and sport.....	p. 7
	Gender and Sexuality.....	p.8
	The role of culture in the development of ‘eating disorders’	p.9
	The impact of the media on body image.....	p. 9
	Exploratory studies into the development of eating problems in men.....	p. 10
	Are men seeking help for ‘eating disorders’?	p. 11
	Males and seeking help for mental health problems.....	p. 12

Stigma and shame: Men's experience of seeking help for 'eating disorders'	p. 13
<i>Society's perception of men with 'eating disorder'</i>	p. 13
<i>Men's perception and understanding of 'eating disorders'</i>	p. 14
<i>Professional perception and response to men with 'eating disorders'</i>	p. 15
Treatment for men with 'eating disorders'	p. 17
Importance and relevance for clinical psychology	p. 19
Summary and conclusions	p. 20
Research questions and aims	p. 21
3. METHODOLOGY	p. 22
Qualitative method	p. 22
Epistemological stance	p. 23
Interpretative Phenomenological Analysis	p. 23
Why not a different qualitative method?	p. 24
The researcher in context	p. 26
Sampling	p. 27
Written materials	p. 28
Research participants	p. 29
Recruitment	p. 29
Data collection	p. 30
Analysis	p. 32
Validity and quality	p. 34

Ethical considerations.....	p. 34
Potential distress to participants.....	p. 35
4. ANALYSIS.....	p. 36
Boys should be boys and men should be men.....	p. 38
Boys should be boys.....	p. 38
Experience of society's perception of men, bodies and 'eating disorders'.....	p. 42
Experience of being a man and seeking help.....	p. 45
The experience of interpersonal relationships.....	p. 51
The impact of the 'eating disorder' on relationships with others.....	p. 51
The influence of others in seeking help.....	p. 56
The 'eating disorder' as both the problem and solution: Negotiating a road to recovery.....	p. 60
Punishment	p. 60
Eating disorder as a means to achieve and stand out.....	p. 64
The process of establishing a new sense of self and the difficulty of letting the 'eating disorder' go.....	p. 69
5. DISCUSSION	p. 73
Boys should be boys and men should be men.....	p. 73
Implications and recommendations.....	p. 76
The experience of interpersonal relationships.....	p. 78
Implications and recommendations.....	p. 81

Eating disorder as both the problem and solution: Negotiating a road to recovery.....	p. 82
Implications and recommendations.....	p. 85
Evaluation of qualitative methodology.....	p. 85
Limitations to the study.....	p. 89
Future research.....	p.91
Conclusion.....	p. 93
REFERENCES.....	p. 94
APPENDICES.....	p. 108
Appendix 1: Summary of the study.....	p. 108
Appendix 2: Information sheet.....	p. 109
Appendix 3: Consent form.....	p. 110
Appendix 4: Original interview schedule.....	p. 111
Appendix 5: Revised interview schedule.....	p. 112
Appendix 6: Extract from research journal.....	p. 113
Appendix 7: An example of the transcript	p. 115
Appendix 8: Extract from Thomas' annotated transcript.....	p. 116
Appendix 9: Emergent themes from Henry's account.....	p. 118
Appendix 10: List of potential superordinate and subthemes.....	p. 123
Appendix 11: Mind map for emerging themes across participants.....	p. 129
Appendix 12: Mind map with for within-participant themes	p. 130
Appendix 13: Approval letter.....	p. 131

1. ABSTRACT

Objective: The silence around 'eating disorders' in males is reflected in a dearth of literature on prevalence, aetiology, treatment and outcome (Morgan, 2010). Despite a documented increase in male 'eating disorders' (Braun et al., 1999), recent research has found that males often reach help at a later stage than females, that symptoms go unrecognised in a clinical setting, and that even when males do receive a diagnosis, appropriate care is not always initiated (Copperman, 2000). The current study aimed to gain an in-depth understanding of the experience of males with 'eating disorders' (in the UK), using a qualitative approach. The study explored men's experiences of living with an 'eating disorder', including their understanding of the development of the 'eating disorder' and their experiences of seeking help.

Method: Eight men were recruited from a self-help charity for men who identify as having an 'eating disorder' (thereby including males who had not sought professional help). Semi-structured interviews of eight men were analysed using interpretative phenomenological analysis, which provided scope to capture and contextualize the richness and complexity of their experiences.

Results: Three superordinate analytic themes are presented: 'boys should be boys and men should be men', 'the experience of interpersonal relationships' and 'the 'eating disorder' as both the problem and the solution: Negotiating a road to recovery.' A description of these superordinate themes and the related subthemes themes is presented.

Discussion: The results are discussed in terms of relevance to existing literature. The results reinforce the importance of considering the development and maintenance of 'eating disorders' at an individual, interpersonal and sociocultural level. The present study sheds light on some of the critical issues confronting men (at different stages of their lives) and the relationship of these issues with constructions and expressions of masculinity and to the development of 'eating disorders'.

2. INTRODUCTION

Overview

The current study is an Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009) of men's accounts of understanding and seeking help for problems with eating.

This chapter presents a narrative review¹ of the literature to date that surrounds men with eating problems and 'eating disorders' ('EDs')². The aim is to critically consider the existing knowledge of and about men with eating problems and highlight important issues within the literature. Key areas will be discussed including: current definitions; incidence, prevalence and prognosis; current research into 'ED' aetiology in men; men's relationship to seeking help for eating problems; and the importance and relevance of exploring this topic for clinical psychology.

This process will help position the present research within existing and relevant literature, with the aim of justifying the value and contribution that the present study can bring to developing knowledge in the field of men with eating problems.

'Eating Disorders': Current definitions

The current Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Society, 2000) divides 'EDs' into three diagnostic categories: 'Anorexia Nervosa' ('AN'), 'Bulimia Nervosa' ('BN'), and 'Eating Disorder Not Otherwise Specified' ('EDNOS'). The 'EDNOS' category includes individuals

¹ A narrative review, allowing for a more comprehensive and open approach to exploring existing literature in underdeveloped areas, was selected as the most appropriate research approach to review the area of men with 'eating disorders'. The approach recognises that the researcher may reformulate the focus of the review in the course of carrying it out (Hammersley, 2003). The narrative review explored concepts including 'men with mental health difficulties', 'men with eating disorders', "eating disorder" development, 'men's experiences of having an 'eating disorder'".

² In acknowledgement of significant pitfalls surrounding the use of diagnoses, I have chosen to bracket the label of 'eating disorders' within inverted commas (Boyle, 1990). Furthermore, although differences may be drawn between the terms 'ED' and 'eating problems', the terms have been employed interchangeably as judged for ease of read and flow in style of the text.

who do not quite meet the criteria for either 'AN' or 'BN' as well as those who fulfill the suggested category of 'Binge Eating Disorder' ('BED'), which involves binge eating associated with emotional distress, but without engagement in compensatory behaviours. In practice, 'BED' has already come to be accorded the status of a diagnostic category in its own right (Palmer, 2005).

Despite the diagnostic criteria clearly differentiating between types of 'EDs', it is well acknowledged that there is significant overlap between 'AN' and 'BN' in terms of symptomatology and aetiology (Vitousek, 1996). This has led to the development of trans-diagnostic theories of 'EDs', which identify the causal and maintaining factors common to all forms of 'EDs' (e.g. Fairburn, Cooper & Shafran, 2003), and to criticism of current diagnostic systems (e.g. Palmer, 2005; Waller, 1993, 2008).

Beyond the professional definitions, having an 'ED' or an eating problem can mean very different things to different people. Postmodern critiques of the current categories and discourse of 'EDs' have argued that the psychiatric definition of 'AN' is socially constructed through language and the different forms of knowledge that have emerged throughout various historical periods in western society (Hepworth, 1999).

The current study acknowledges the difficulties and controversies in the current criteria. It was therefore decided that the study should focus on men who have accessed a self-help charity (Men get eating disorders too (MGEDT))³ for men who identify themselves as currently having or previously having had a problem with eating⁴, rather than specifically requiring these men to adhere to a set of diagnostic criteria to qualify as having an 'ED'.

³ The charity MGEDT states that 'EDs' are: serious emotional and physical illnesses in which sufferers use food and sometimes exercise in different ways to manage difficult circumstances in their lives and the feelings that come with them.'

⁴ Adopting this approach encouraged the emphasis to be placed on the *men's* perception of having an eating problem, rather than being guided by psychiatric definitions of 'EDs' (although it is acknowledged that individual and social constructs of 'EDs' may be interrelated).

Why focus on men with ‘eating disorders’?

To the public and many professionals, ‘EDs’ are primarily associated with girls and young women. Owing to a powerful assumption that ‘EDs’ are a women’s condition, ‘EDs’ in men have been overlooked, understudied, and under-reported (Greenberg & Schoen, 2008). The silence around ‘EDs’ in men is reflected in a dearth of literature on prevalence, aetiology, treatment and outcome. Furthermore, a review into ‘ED’ provision for men in the United Kingdom (UK) (Copperman, 2000) documented that symptoms indicative of eating problems in men are often unrecognised in a clinical setting. In fact, the biggest roadblock to diagnosing ‘AN’ in males may be that clinicians consider males to be immune to the problem: *‘The diagnosis of males with ‘EDs’ is usually a straightforward process, but first you have to think of it as a possibility’* (Andersen, 1990, p. 133). Even when men do receive a diagnosis, there are concerns that appropriate care is still not initiated (Morgan, 2010).

The study of male cases opens intriguing opportunities to develop our knowledge of aetiology and presentation of ‘EDs’ in general, and of ‘EDs’ in men specifically. Very few disorders in general medicine or psychiatry report such a marked skew in gender distribution in prevalence data (Jones & Morgan, 2010). This raises a number of questions: Why are there not more reports of males with ‘EDs’? How do these males compare to females in terms of presentation, course and treatment? ⁵ What factors are implicated in the development of ED’s in males?

Incidence, prevalence and presentation of men with ‘eating disorders’

Recent trends in industrialised countries sharing an emphasis on the value of thinness suggest that eating disorders may be increasing in males, perhaps altered in form from the typical presentation in women.

(Andersen, 1990, p.14)

⁵ It is acknowledged that the enactment and construction of gender is set within and influenced by multiple contexts, therefore highlighting the importance of valuing unique experiences of being male rather than adopting a binary definition of gender.

Incidence and Prevalence

In 1694, Richard Morton recorded the first case of sudden loss of appetite, without reason of medical disease, in an adolescent male (Silverman, 1990). Although the first historical publication of an 'ED' describes a boy with 'AN', there is actually very limited epidemiological data from community samples documenting the prevalence of 'EDs' in male subjects. Broadly speaking, prevalence studies are difficult to confirm as a result of the reported bias in diagnosing 'EDs' in females compared to 'EDs' in males (Jones & Morgan, 2010), the low awareness of 'EDs' in men, and a subsequent misinterpretation of symptoms by both families and sufferers alike. Furthermore, the few studies that do focus on male cases of 'EDs' are often considered to suffer from methodological shortcomings, including a lack of methodological consistency in sample selection and inclusion criteria (Stiles, 1993). Most instruments for identifying 'EDs' were designed for, and evaluated on, female samples, which may cause some core psychological issues of men with 'EDs' to be overlooked as a result.

Despite the clear drawbacks to existing epidemiological literature, numerous studies and clinical feedback in the field support a significantly decreasing gender gap in the occurrence of 'EDs' (Morgan, 2010). Whilst there may be some discrepancies around the exact figures of males with clinically significant 'EDs', literature consistently suggests that men are not seeking help, or accessing services as readily as females (Copperman 2000; Morgan, 2010). The existing studies suggest that men may represent up to 10-20 per cent of cases of 'AN' and 'BN' and up to 40 per cent of cases of 'BED' (Muise, Stein & Arbess, 2003). A gender difference is supported by both clinical series and epidemiological studies (Andersen, 1992).

There are some indications that men are increasingly accessing service for treatment of 'EDs'. Braun et al. (1999) reported that in the USA, the percentage of all first inpatient admissions of men with 'EDs' patients had increased from two to nine per cent between 1984 and 1997. The authors concluded that there appeared to be a higher threshold for men to seek treatment for a typically 'women's problem' but it is possible that this threshold may have been reduced

over time due to heightened awareness in the public, media publications and increasing levels of awareness in health care professionals.

Presentation

The research regarding similarities and differences in 'ED' presentation between males and females has provided somewhat inconsistent results. Several authors are in agreement with the finding that 'ED' symptomatology, specifically in 'AN' and 'BN', is reasonably similar for males and females (Carlat, Carmago & Herzog, 1997; Braun et al., 1999; Woodside et al., 2001). However, some studies, particularly those focused on the 'shape' of the individual, suggest that there *are* areas of symptomatology where 'EDs' in males seem to differ significantly from 'EDs' in their female counterparts. Research suggests that men are more likely than women to desire a muscular body (Weltszin et al., 2005; Muise., et al 2003). Several groups also reported an increased tendency in males with a diagnosis of 'AN' to exercise excessively compared to females with 'AN' (Crisp, Burns & Bhat, 1986; Sharp et al., 1994). More recently, Meyer et al. (2005) found that bulimic psychopathology was associated with anger suppression in women but not in men, suggesting that bulimic behaviours may have a different function for each gender.

Issues in the development of 'eating disorders' in males

Andersen (1995, p1) reports that, while 'EDs' may appear similar for both males and females, the course for getting there is often very different:

*When individuals are very ill, suffering from emaciation...
they appear very similar and require similar treatment...but as
patients become medically healthy and the symptoms are
deconstructed, the individual life story behind each patient
unfolds to reveal differences between the sexes in
predisposition, course, and onset.*

It is well acknowledged that 'EDs' are complex and multi-factorial: an array of factors have been implicated in the developments of 'EDs' including neuropsychological, biochemical and sociocultural (Abraham & Llewellyn-Jones

2001). While it is beyond the scope of this chapter to provide a full review of research concerning the causes of 'EDs', there are a number of factors (outlined below) that are considered of significance in the development of men with 'EDs'.

Body awareness in boys

It has been suggested that negative experiences of one's body, weight and shape in childhood can contribute to the development of 'EDs' in males (Morgan, 2010). Copperman (2000) supported this claim, finding that experiences of childhood bullying and teasing for being overweight often precluded 'EDs'. A survey undertaken by the Teachers Union association of 693 members across the UK found that 51 percent of those interviewed considered boys to have low confidence in their body image (BBC, 2013). A study that employed in-depth interviews with 34 young boys at primary school in Australia explored this notion further. Drummond (2003) found that, for young boys, the body plays an important role in the construction of masculinity. However, rather than how the body *looked*, the boys identified what the male body can *do* as being particularly significant to their conceptualisation of masculinity. The influence of others in the experience of one's own body is supported by Vincent and McCabe (2000) who found that 11-17 year old boys were more influenced than girls by negative peer commentary about weight and shape.

Athletics and sport

Involvement in athletics may in fact perpetuate or even lead to the development of EDs in males (Baum, 2006). Some studies suggest that athletes are actually at higher risk than non-athletes of developing an 'ED'. It has also been suggested that there are some sports where this may be particularly likely, such as sports with an emphasis on aesthetics and sports where low body fat is considered advantageous (Biesecker & Martz, 1999). Davis (1999) remarks that involvement in routine exercise, in particular aerobics and weight training, has been linked to body dissatisfaction and a tendency to diet, which in turn may lead to 'eating-disordered' behaviours. Goldfield, Harper, and Blouin (1998) suggest that an increase in bodybuilding and weightlifting has paralleled sociocultural norms with a mesomorphic build as the ideal male body type. Despite these findings, there remains significant stigma surrounding psychiatric

health difficulties in the athletic arena, in particular with male athletes, and these difficulties often remain undiagnosed and untreated (Baum, 2006).

Gender and sexuality

Several authors have reported that homosexual conflict preceded the onset of an 'ED' in up to 50% of male patients (Scott, 1986; Dally, 1969; Crisp, 1967). Herzog, Bradburn and Newman (1990) found that men who identified as homosexual weighed considerably less than heterosexual men, were more likely both to be underweight and to desire an underweight ideal. Compared to heterosexual men, homosexual men were less satisfied with their body build, and scored significantly higher on the 'Drive for Thinness' scale of the 'Eating Disorders Inventory' (EDI) (Garner, Olmsted and Polivy, 1983).

There appears to be a stereotype of the typical male with a diagnosis of 'AN'. This profile commonly yields the image of an effeminate, homosexual male model, actor, or dancer. There is some suggestion that males who identify as homosexual, experience similar pressures to those felt by women to maintain a thin and youthful appearance (Herzog et al., 1990; Siever, 1994). Traditionally psychologists suggested that the association between homosexuality in men and the development of 'AN' was a result of the conception that homosexual men had a greater identification with feminine characteristics. However, Russell & Keel, (2002) found that homosexual men struggled with unique social expectations that were unrelated to feminine issues, often considered to be contributory to the occurrence of 'AN' in this population. Literature in this field has mostly employed a quantitative approach to investigate homosexuality as a significant risk factor to the development of 'EDs' in men (Carlat, Camargo & Herzog, 1997; Russell & Keel, 2002). It may be argued, however, that in light of the acknowledged complexity of the development of 'EDs', the area would benefit from adopting an exploratory approach. This approach may provide greater insight in to the perspectives of the men themselves on the potential role of sexuality in 'ED' aetiology.

The role of culture in the development of 'eating disorders'

Cultural beliefs and attitudes have been identified as a significant factor in the development of 'EDs'. Furthermore, the prevalence of 'EDs' has been found to change across time as culture evolves. In particular, the increasing idealisation of a particular body type in the western society is recognised as a possible factor in the development of 'EDs' (Miller & Pumariega, 2001). Initially it had been assumed that 'EDs' occurred almost exclusively in upper socioeconomic groups within western nations and that 'EDs' were found predominately in white individuals in Western orientated countries. However, to the contrary, there is evidence that 'EDs' occur in a diverse range of cultural, socioeconomic and ethnic groups (Dolan, 1991). Over the past decade, there has been increasing evidence of 'EDs' occurring among ethnic minorities in the United States. Contrary to the belief that 'EDs' affect only young, white women, Story et al. (1997) concluded that dieting was associated with weight dissatisfaction, perceived overweight, and low body pride in all ethnic groups. Despite an increased focus on the role of culture in the development of 'EDs' in women, little is known about the prevalence of 'EDs' in men across culture and the role of culture in the development and maintenance of 'EDs' in men. A recent study found that in a group of Canadian men, ethnicity was indirectly related to 'ED' symptomatology through spirituality, body shame and BMI. The study concluded that Asian men experienced greater body shame (Boisvert, 2012). These findings have implications for the development of interventions for men with 'EDs'. Further research is needed to gain a greater understanding of the role of culture in the development of 'EDs' in men and the implications this may have for the prevention and treatment of 'EDs' in men.

The impact of the media on body image

The media plays an important role in how we define ourselves and what is perceived as the 'ideal' for both men and women. Males as well as females are increasingly exposed to powerful, distorted and destructive definitions of perfection. Bordo (1999) argues that *'beauty has (re) discovered the male body'* based on the observation that men are being put on display more frequently in society (p. 168). Recently, there has been an increased onus on male aesthetics

(fuelled both by commercial greed and the media) promoting a certain male body shape, and as a result an increasing social pressure on men to have low body fat and high muscularity (Leit, Pope & Gray, 2001; Pope, Olivardia, Gruber & Borowiecki., 1999). For males, the popular ideal has accentuated superior physical strength and athletic prowess (Kearney-Cooke & Steichen-Asch, 1990).

While it is easy to blame the media for its role in promoting a culture of idealised body shapes, it is noteworthy that a lack of general awareness of 'EDs' in males in the community was found to be a barrier for accessing help and recognising 'EDs' (Copperman, 2000). The media has a crucial role in promoting awareness of 'EDs' in males and bringing 'EDs' to the attention of the public. It was found that referrals for males with 'EDs' tend to increase immediately after prominent television programmes focused on male 'EDs', and then decrease once the media is no longer focused on this topic (Morgan, 2010). BEAT (2008) confirmed this pattern, finding that, immediately following the revelation of an ED by John Prescott, the BEAT helpline received ten times as many calls as normal. This finding emphasises the importance of increasing understanding around the process of the media in promoting awareness of 'EDs' in males.

Exploratory studies into the development of eating problems in men

The conducted literature research suggested that the majority of research into 'EDs' in men has been quantitative in its approach. It may be argued that, at times, the dominance of a quantitative approach in this field, has led to assumptions being made around gender-specific causal factors considered to be key determinants of developing an 'ED'. The literature search on the development and experience of 'EDs' identified few studies that report on men's own perception and understanding of developing a problem with eating (Drummond, 1999, 2002; Copperman, 2000).

Drummond (2002) employed an inductive approach to draw themes from interviews with ten Australian men who had contacted a voluntary agency. Whilst the paper has been criticised because of its lack of demographic information within which to situate the sample and a lack of rigorous methodological framework (Stiles, 1993), its findings are interesting and provide an insight into the perspective of the males themselves and thus a foundation

for further exploratory research in this area. Drummond (2002) found that men used the 'ED' as a means to propping up their masculine identity: being diagnosed as 'anorexic' or 'bulimic' added to their sense of masculine identity. The men also issued strong claims in wanting to be devoid of fat. In a follow-up study specifically focused on men who identified themselves as homosexual and as having an 'ED', men reported that muscularity was an important factor in defining masculinity, strength and attractiveness (Drummond, 2005). The outcomes revealed by these studies provide a useful insight into the perspective of men in Australia around factors implicated in the development of 'EDs'.

Are men seeking help for 'eating disorders'?

Literature consistently suggests that males are not seeking help or accessing services as readily as females. The Eating Disorders Association (EDA; now BEAT) commissioned a study, which asked ten British men about the accessibility and acceptability of 'ED' services through semi-structured telephone interviews (Copperman, 2000). The mean time it took for 10 men to reach help was six years, the longest reported was no shorter than 14 years. Another study found that, although at least 10 percent of people with 'EDs' are males, in some 'ED' services less than one percent of clients are males (Morgan, 2010). Descriptive results from Copperman's study (2000) reported the lack of recognition by General Practitioners (GP) of 'EDs', the difficulties of discussing 'EDs' with peers, and the importance of support from family, friends and professionals to access services. Having contact with other men with 'EDs' was seen as more important than the gender of the professional or their knowledge of men's issues.

More recently, a UK-based qualitative study interviewed men from a specialist 'ED' service about their experience of being a man diagnosed with an 'ED'. Robinson, Mountford & Sperlinger (2012) found that men experienced difficulty in admitting their 'ED' (for fear of negative reactions from those around them) and felt invisible to peers and professionals alike. Men also discussed the negative implications of being a male in treatment for an 'ED'.

Despite evidence that a large percentage of men with 'EDs' do not access

speciality care, little is known about barriers to accessing care for those who do not reach specialist services (in particular within the UK). It will be important for research to untangle the factors contributing to men not reaching services. For example: is the help provided tailored to the needs of men? Do they want to access services? If not, what are the reasons for them not choosing to? With these questions remaining unanswered, there are worrying repercussions of men not accessing care tailored to their needs and a worse prognosis in males compared to females (Burns & Crisp, 1985). This pattern of a delay in men accessing care is reflected and supported by existing literature documenting men's relationship to help in other areas of mental health.

Males and help seeking for mental health problems

There has been a surge of popular writing and research across various academic disciplines centering on males' reluctance to seek help for both physical and mental health problems. Several studies have found that men are less likely to seek help for psychiatric counselling and psychotherapy services than women (Gove, 1984; Vessey & Howard, 1993). Research confirms that this pattern is common across men of various nationalities (Mahalik, Walker & Levi-Minzi 2007).

There have been a number of overlapping attempts to explain men's reluctance to seek help. One explanation suggests that men are less aware of their bodies and their own experiences (Leong & Zachar, 1999; Addis & Mahalik, 2003). This theory suggests that the reluctance to seek help is primarily an 'information' issue and that 'not knowing' is a result of a lack of education. An alternative explanation is that, although men are aware of their bodies and mental health difficulties, they choose not to speak about them. The implication of this preference is that not to seek help is an internal and personal wish. Discussing problems may be viewed as a sign of weakness, as is having a problem in the first place (Addis & Mahalik, 2003). Lastly, a popular approach is to understand men's attitude to help seeking as a product of masculine gender role socialisation (Pollack 1998; Real, 1997). For example, many of the behaviours associated with seeking help from a health professional, such as relying on others and labelling an emotional problem, conflict with messages that men

receive about physical toughness and prowess (Courtenay, 2000; Addis & Mahalik, 2003). This approach suggests an implication of 'deviating' is that society will bring external pressure to bare upon the non-conformist. In support of this approach, Good, Dell and Mintz (1989) found that males who endorsed concerns about expressing emotion and traditional attitudes around the role of males also endorsed more negative attitudes towards seeking help. Mahalik et al. (2003) extended this theory and suggested that men are influenced by normative, masculinity messages. For example, as 'EDs' in men are often considered to be a 'female disorder', it is possible that men associate such behaviours as being effeminate and non-normative, as they are not frequently observed in other men.

These theories propose frameworks to better understand the reluctance of males to seek help for psychological problems. Whilst there is increased attention to this area, it is important to acknowledge the drawbacks of adopting a theory based on a binary understanding of male and female behaviour, and remain aware of the differences in the construction and enactment of gender across multiple layers of context (Blazina & Shen-Miller, 2011).

Stigma and shame: men's experience of seeking help for 'eating disorders'

Literature in the field of 'EDs' specifically attends to a number of areas that may be implicated in men's experiences of seeking help. These areas include the understanding and perception of male 'EDs' within society, amongst professionals, and in male sufferers themselves. Whilst each area will be discussed separately, it is acknowledged that these areas are inevitably interconnected, and impact on each other.

Society's perception of men with 'eating disorders'

During the 19th century and much of the 20th century, the idea that males can suffer from 'EDs' as well as females has mostly been neglected by research and silenced by society (Morgan, 2010). This is despite the fact that some of the first examples of 'EDs' in the English language include examples of males (Morton, 1694). During the late 19th and early 20th centuries, 'EDs' in men were theorised out of the public domain and neglected by numerous academic fields.

For example, the traditional psychodynamic hypothesis of fear of oral impregnation (Morgan, 2010) as an explanatory concept in 'EDs' cannot apply to men. On a societal level, it is possible that men were overlooked merely because of their failure to fit the prevailing stereotype. The doubt surrounding the existence of male EDs has remained throughout much of the 20th century, despite a marked increase in the recorded prevalence of 'EDs' in men over the last 50 years (Garfinkel & Garner, 1982; Carlat et al., 1997). Crisp et al. (2000) found that lay people continued to consider 'EDs' as being self-inflicted and easily curable.

Why does this discourse persist? Morgan (2010) argues that it is reinforced by government action, policy and the media. For example, in the year 2000, the British government hosted a body image summit, in which they debated the way that young women saw their bodies and explored the reasons behind the increase in female 'EDs'. The summit failed to acknowledge that men increasingly, are exposed to social pressures of aestheticism, especially as, evidence suggests an intensified connection between men and their bodies regarding both how their bodies are represented and how men feel about their bodies. Morgan (2010) argues that the outcome of this summit was to employ gender bias in an area that goes beyond gender. It is possible that cultural stereotypes of 'EDs' in males (reinforced by actions such as the aforementioned) provide a strong barrier to accessing care (Copperman, 2000).

Men's perception and understanding of 'eating disorders'

There are misconceptions and myths around male 'EDs' that impact on the ability of professionals, sufferers and sufferers' families and peers to recognise and respond to 'ED' symptoms in males.

A study into the provision of services for male 'EDs' concluded that there are clear indications that the general lack of recognition of 'EDs' in men makes it more difficult for men to access services (Copperman, 2000). In support of this, McVittie, Cavers and Hepworth (2005) examined the ways in which male college students comprehend 'AN' in men. The results supported the notion that society as a whole still views 'EDs' as a problem predominantly found in women.

Consequently, men are less likely to recognise, acknowledge and understand their own problem as an 'ED' or indeed a problem that requires help.

Men with 'EDs' are particularly at risk of stigmatisation not only from people around them but also from themselves (Morgan, 2010). The everyday understanding of 'AN' that strongly connects the 'eating disorders' with feminine characteristics, has made it difficult for men who consider themselves to have a problem with eating to seek help, out of fear that they will not be taken seriously or that they will be considered 'less masculine' according to prominent social constructions of masculinity. A recent study found that men saw themselves as less masculine when acknowledging an 'ED', whereas it was found to be less threatening to a woman's identity. There is a dominant stereotype that 'EDs' are predominantly a 'female disorder' or that it only affects males who identify as homosexual, which leads to 'shame' due to internalised stigmatisation and personal discomfort surrounding sexuality (Freeman, 2005).

In support of the finding that sufferers themselves experience difficulties in recognising and responding to 'EDs', it was found that male service-users requested more information, the opportunity to contact other males with 'EDs' and the introduction of an awareness campaign, targeted specifically at facilitating recognition by GPs in primary care, parents, and teachers, as well as within student unions and health centres (Copperman, 2000). Although it is recognised that there is low awareness of 'EDs', research has paid little attention to exploring males' experiences (in the UK) of developing and seeking help for eating problems.

Professional perception and response to men with 'eating disorders'

A report concluded that a lack of familiarity with men with 'EDs' amongst professionals leads to a delay in evaluation, diagnosis and referral and a consequent increased risk of medical complications (Siegel, Hardoff, Golden & Shenker, 1995). Because of these barriers to accessing care, once men do receive adequate treatment, they are often at a later stage of the 'disorder' and receive a poorer prognosis than would otherwise have been the case. These issues raise concerns around mental-health utilisation amongst males with 'EDs'

and emphasise the importance of recognising male 'ED' issues as an area of serious health-concern (Copperman, 2000).

In the view of specialist services, the role of the GP is essential in assisting men with 'EDs' to access appropriate care and particularly in locating specialist services for males with 'EDs' (Copperman, 2000). It is of significant concern, therefore, that health professionals are often unfamiliar with the manifestation of 'EDs' in males (Morgan, 2010). There may be a number of factors that account for this lack of awareness of male 'EDs' in professionals.

It is possible that the lack of awareness of gender-specific characteristics of 'EDs' is reinforced by the current diagnostic system. Morgan (2010) has emphasised a number of issues with the current diagnostic criteria or the interpretation of criteria by professionals. The planned DSM-V (DSM-V development website, 2012) does not state equivalent requirements in men and women for diagnosis of 'AN' and consequently, physicians are often unaware of gender-specific differences (Freeman, 2005). Currently, Morgan argues that the diagnostic criteria are expressed in female-specific symptoms of 'AN'. For example, 'AN' is often interpreted as a 'syndrome' in which an individual persistently strives for a thin body. In addition, the 'syndrome' is characterised by progressive weight loss, amenorrhea (to be removed with DSM-V) and a significant body image distortion (Morgan, 2010). By focusing specifically on the female manifestation of 'EDs', it can be argued that the criteria fails to consider symptoms found in males, which are more likely to include low body fat, and a pursuit of muscularity and strength achieved by increased exercise.

Unfortunately, this lack of awareness amongst professionals extends beyond that of the GPs.

It is perhaps surprising that men continue to receive such a low profile when one considers that a UK-based review of 'ED' provision for men has documented a concerning lack of awareness in a number of professional disciplines (Copperman, 2000). For example, one psychiatrist refused to accept that males ever suffered from 'BN'. Professionals were much more likely to carry out physical investigations of men with 'EDs' and tended to neglect psychological aspects which may have increased the likelihood of a diagnosis. The low

awareness of 'EDs' in males is reflected in the lack of specialist treatments available for males with 'EDs'. Even in specialist services, only one service was identified as providing gender-specific care. Whilst some services saw the inclusion of males in female psychotherapy groups as helpful, others resisted including males if possible. The study suggests that a lack of professional awareness has a crucial impact on men's experience of accessing and receiving professional care.

Numerous studies indicate that 'EDs' in males are not sufficiently recognised in a clinical setting, owing to diagnosis bias and society's lack of awareness in the area. However, most of the discussion in this area involves dissection of the current diagnostic system or investigations of professional awareness of 'EDs' (Morgan, 2010). There is a distinct lack of research that has focused on enabling men to voice their unique experiences of the barriers they faced in seeking help or accessing care, or of the care or response they received once they had sought help (Robinson, 2012). Given the unawareness and unwillingness of professionals to make a formal diagnosis, the importance of exploring the experiences of males who have accessed non-specialist care seems a particularly important area on which research should focus.

Treatment for men with 'eating disorders'

There are currently no specific guidelines for males with 'EDs' (National Institute for Health and Excellence, 2004). However, recent movements by the Department of Health (DoH) to eliminate mixed-sex accommodation may impact on the accessibility of treatment for men with eating problems (DoH, 2009). Unless male-specific options are available, and supported by convincing literature, it is possible that men may miss out on gender-specific specialist support on an in-patient ward. These imminent developments further highlight the need to explore the role of gender in the development of 'EDs' that may be important in the implication of male-specific interventions within specialist services.⁶

⁶ While this section focuses on treatment within a professional context, it is also acknowledged that there are alternative forms of non-professional help that may be of considerable value in the process of recovery for men with 'EDs'.

There is mixed evidence regarding the need for sex-specific treatment of 'EDs'. While Andersen and Holman (1997) argue that 'ED' treatment should follow the same broad principles regardless of sex, they acknowledge that role and social functioning should be addressed during treatment. Other authors have argued for the need for recognising the unique requirements of males with 'EDs' through the use of all-male treatment environments (Weltzin et al., 2005). Weltzin et al. (2005) cited unpublished data in which men have identified the importance of all-male therapy groups; they have reported that men feel out of place in groups that discuss female issues, and feel stigmatised by female peers with 'EDs' (Andersen & Holman, 1997). Greenberg and Schoen (2008) suggest integrating a psychology-of-men perspective in 'ED' treatment. The authors propose that in addition to standard treatment principles, concepts such as gender role conflict, masculine identity and emasculation should be considered and addressed when treating the male population. Additionally, each factor of male 'AN' should be addressed in the context of the current social constructs of masculinity, acknowledging that there is not one 'right way' to help and support men with 'EDs'. These findings further emphasise the importance of acknowledging the unique experience of the individual with an 'ED' (situated within multiple layers of context), rather than making assumptions based on binary definitions of gender.

Recent outcome studies have outlined the benefits of both male-specific and non-gender specific treatments. An evaluation of an American multi-disciplinary male-specific residential 'ED' treatment programme consisting of 105 males diagnosed with different diagnoses of 'EDs' (Weltzin, Weisensel, Cornella-Carlson & Bean., 2007) found that the multidimensional approach resulted in statistically significant improvements in both the severity of the 'ED' symptoms and in weight changes, measured by the EDI (Garner et al., 1983). These improvements were found to persist one year after discharge from the residential treatment. A Spanish study comparing male and female outpatient Cognitive Behavioural Therapy for 'BN' (Fernandez-Aranda et al., 2009) showed both reductions on measures of 'ED' symptoms and in the following subscales: 'drive for thinness', 'body dissatisfaction' and 'interoceptive awareness'. While these results are certainly encouraging, there is a distinct lack of qualitative

studies based in the UK, and neglect in asking men themselves to tell their own story of seeking help (or not seeking help). Further exploratory research is needed in order to gain a richer understanding of the complexities of the help-seeking process for males (for those who have and have not accessed non-specialist care) and the factors that affect males in reaching a point nearer to their own unique understanding of recovery.

Importance and relevance for clinical psychology

Further research is needed to focus on and improve the understanding of men's experiences of developing an 'ED' and their journey to accessing help for this problem. There is a distinct lack of qualitative research exploring factors that have been acknowledged in the female literature and their relevance to males with 'EDs', for example, the role of socio-cultural influences in the development and maintenance of 'EDs'. It is critical to obtain men's accounts of their experience of 'EDs' in the UK. This would both develop the understanding of potential risk factors associated with 'EDs' in males and also highlight crucial elements necessary to introduce successful male-targeted interventions.

Considering in detail the unique experiences of those who have encountered such difficulties is important to guiding theory, instead of simply adopting a 'top-down' theoretical approach (Drummond, 2002). Clinical psychologists have a central role in developing and increasing the availability and accessibility of psychologically based interventions for men with 'EDs'. They are in a key position to contribute to furthering research in the field of men with 'EDs'. By utilising their consultative skills, they are also well placed to train other health professionals in delivering such treatments and at a broader level, to influence public policy.

Summary and conclusions

- Literature indicates that there is less awareness and acceptance of 'EDs' in males than there is of 'EDs' in females, not only at a broad societal level, but also amongst professionals, males with 'EDs' and their immediate social network (Morgan, 2010). Males are less likely to seek help for 'EDs' and when they do access help, they are less likely to be transferred for treatment than their female equivalents.
- There is a dearth of literature in this area focused on the development of 'EDs' in males and the factors implicated in the help-seeking process. Research that *does* exist often employs a quantitative approach. The richness of data available through qualitative analysis can add critical depth to quantitative studies that exist within the literature.
- Research has not explored men's individual experiences (in the UK) of living with an 'ED' or the process of help-seeking in males who have accessed non-specialist care. Such research may shed light on factors found to influence the process of seeking both professional and non-professional help.
- Causal factors of 'EDs' in males, components of effective interventions, and experiences that impact on maintenance are complex, multifaceted and require further research in order to enhance understanding in this area.

Research questions and aims

The aim of the present study was to explore how men (in the UK) made sense of the development of an 'ED' and their experiences of living with and seeking help for the 'ED'. The research was interested in contextualising participants' experiences of having an 'ED' within each individual's unique context and how they made sense of their experiences. In line with these objectives, the research questions were purposively broad⁷:

1. How do men understand the development of the 'ED'?
2. How do men describe what it is like to live with an 'ED'?
3. What are/were men's experiences of others' (professionals/peers/family) during the 'ED'?
4. What are/were men's experiences of seeking help for the 'ED'?

⁷ It is acknowledged that the four main research questions are interrelated and therefore there may be some degree of overlap in participants' responses to these areas.

3. METHODOLOGY

This chapter details the methodological and epistemological approach adopted for the research. A detailed account of the procedures involved in data collection and analysis is provided, along with participants' relevant demographical data and ethical considerations.

Qualitative methodology

A qualitative methodology is especially appropriate for exploratory objectives, attending closely to process and individual differences, meanings and contexts (Yardley, 2000). On the contrary, quantitative research, which is informed by a positivist assumes empirical facts exist aside from personal ideas or thought. The purpose of quantitative research is to remain objective and to capture and accurately represent an objective truth or reality (Hammersley, 2000). The qualitative purist rejects the positivist assumption and contends that there are multiple realities that are subjected and socially constructed by participants (Guba & Lincoln, 1994). As such, qualitative research methods allow for a more detailed investigation of issues- exploring questions of meaning, a consideration of who is affected (by the issue), factors that are involved and the opportunity for individuals to respond in their own words (Smith et al., 2009).

Hepworth (1999) has emphasised the importance of qualitative research in the 'ED' field and described the lack of such research as '*a weakness in developing theory and clinical practice*' (p.179; quoted by Colton & Pistrang, 2004). Within the last decade there has been a notable increase in qualitative research aimed at exploring 'EDs' (e.g. Newton, Boblin, Brown & Ciliska, 2005; Mulveen & Hepworth, 2006). However, a narrative literature research indicated a significant paucity in qualitative research exploring the experience of men with 'EDs' (Copperman 2000; Robinson et al., 2012).

With this in mind, and in considering the most effective way to address the particular research question of this study, it was decided to adopt a qualitative methodology. This approach allows for explorations of the richness of the human experience and an opportunity for the voice of the other to finally be heard.

Epistemological stance

The prime reasons for selecting IPA is the approach's consistency with the epistemological stance of the research questions (Smith et al., 2009). My epistemological position is that of critical realism, which sits between (naïve) realism and (radical) relativism. The critical realist stance acknowledges that there are stable and enduring features of reality existing outside of human conceptualisation, but that it is not possible to access these in a vacuum; one is inevitably influenced by their intrinsic subjectivity, beliefs and expectations (Madill, Jordan & Shirley, 2001). Social constructionist concepts also inform this work, which acknowledges multiple realities; that interpretation must also involve consideration of the context (Gergen, 1985).

Madill et al. (2001) argued that it is important to assert one's epistemological position at the outset. However, in doing so, it is acknowledged that the researcher's style and positions can vary within a chosen approach and that it is possible that dependent on the context, the analysis may adopt a more 'critical' or 'realist' stance (Miller et al., 1997).

Interpretative Phenomenological Analysis

The key components of IPA (Smith, 1996) are outlined below alongside the factors that influenced the selection of this approach over other qualitative methodologies.

Firstly, IPA is consistent with the research aims. It is a phenomenological approach that allows for an exploration of experience and people's sense making of major life experiences (Smith et al., 2009). The approach is therefore not limited by attempting to reduce experiences to pre-defined categories, though it does aim to recruit a fairly homogenous group⁸. It was considered important to select a methodology that included the researcher as part of the context and thus acknowledging the researcher's intrinsic subjectivity. In IPA, the researcher is engaged in a 'double hermeneutic'; the researcher is attempting to make sense of the participants' interpretation of what happened to

⁸ Heterogeneity of diagnosis within this study's sample is discussed in the 'Sample' section of this chapter.

them (Smith et al., 2009). The researcher endeavours to carefully balance what Ricour described as the 'hermeneutics of empathy' (the 'phenomenological' element of the analysis), with the 'hermeneutics of suspicion' (the 'interpretative' element)"(1970, cited in Larkin, Watts & Clifton., 2006).

The aim of IPA is to explore in detail how participants are making sense of their personal and social world. IPA is both phenomenological and social constructionist: it is concerned with the personal experience but also allows for interpretation considering the context. The stress placed on social structures and processes (Eatough, Smith & Shaw, 2008) has been argued to be of great importance in the exploration of experience of developing an 'ED' in males (Drummond, 2002).

The idiographic nature of IPA corresponds with the present study's aims of considering individuals' unique experience, and being able to explore the participant group in detail. Within IPA, each individual's account is analysed in depth in its own right: rather than discounting 'exceptions' to patterns, or attempting to categorise them along with other more 'common' experiences, the researcher recognises and values them. The idiographic stance of IPA allows for development in universal understandings by connecting unique experiences to those that considered to be communal findings (Warnock, 1987).

It has been argued that IPA is suited to topics that are both multifarious (e.g. Smith & Dunsworth, 2003) and under researched (Reid, Flowers & Larkin, 2005). Men with ED problems fit both of the aforementioned criteria: research suggests a number of factors that may be implicated in the development of 'EDs', yet there remains a notable absence within the 'ED' field focused on the perspectives of men who identify as having an 'ED'.

Why not a different qualitative method?

In this section, IPA is situated in relation to other possible qualitative methods: Grounded theory, Discourse Analysis and Narrative Analysis.

Grounded theory sets out with the intention of producing a theoretical level account of a particular phenomenon, relying on a larger sample than that recommended in IPA. A grounded theory approach may be considered to be

more of a sociological approach, identifying similarities within large samples to support broader conceptual explanations. In contrast, an advantage in the IPA approach is its tendency to be concerned with the psychological and with giving voice to individual experience (Smith, 2008).

Discourse Analysis (DA) was excluded, as, whilst IPA allows exploration of cognitions and sense making, DA remains cynical regarding the accessibility of cognitions. Within DA there is a strong focus on the role of language in terms of its function in constructing social reality. While the IPA approach recognises that cognitions are not directly available from verbal reports, the analytical process is conducted with the hope of being able to say something about how participants make sense and meaning of these concepts (Smith, Flowers & Osborn, 1997; Smith et al., 2009).

Narrative analysis has developed from social constructionism (Bruner, 1990) and is considered to hold similarities with an IPA approach. The 'double hermeneutic' involved within an IPA approach sets IPA apart from a narrative analysis methodology. In employing an IPA approach, there is the opportunity for the researcher to cautiously consider meanings and processes to which the participants may have alluded and may not have been aware; this is not the case within a narrative approach. Smith et al., (2009) suggest that a clear advantage to an IPA approach is that the researcher can draw on theoretical perspectives, contents and linguistic pattern in their interpretation.

The researcher in context

Prior to embarking on the research I met with Alex⁹ member of the charity 'Men get eating disorders too'¹⁰ (MGEDT) and separately another ambassador for the charity. This opportunity allowed me to increase my experience and confidence in engaging with men who identified themselves to currently have or to have previously had an eating problem, as well as involve the ambassadors in preliminary discussions around the subject of men with 'EDs' and the areas they identified as requiring further research. The discussions included acknowledging misconceptions in the field and assumptions made by professionals. These meetings allowed me to engage in an in-depth level of reflexivity and consider how my own pre-conceptions may have had the potential to affect the interview process.

Subsequent to setting out the epistemological assumptions underpinning the research, it was important to identify the contextual factors which affect one's own position in relation to the research, such as my position as a:

- Woman
- Person without experience of an 'ED'
- Person who has been close to people with an 'ED'
- Researcher
- Trainee clinical psychologist (and therefore a 'professional', active in clinical practice)
- Professional with experience in working with females with 'EDs'
- White British female
- Individual of further educational attainment.

⁹ Pseudonyms used in order to ensure confidentiality

¹⁰ MGEDT is a national charity dedicated to representing and supporting the needs of men with 'EDs' (MGEDT, n.d.).

There have been mixed findings when considering the position of a female researcher interviewing males. Pikus, Christopher and Heavey (1996) found that males did not express a preference for therapist gender. Carlson (1981), however, emphasised the importance of the female therapist having the skills and knowledge base to address the destructive effects of the traditional sex role stereotype on men, when working with males. Overall, there appeared to be a lack of clear findings specifically suggesting that males find it difficult to relate to a female when speaking about problems related to 'EDs' or problems that are associated with females. Despite this finding, it was acknowledged that the difference in gender might affect both the participant's and the researcher's experience of the interview.¹¹

Regular supervision (with both peers and the research supervisor) provided a crucial space to explore the researcher's views and assumptions from alternative perspectives. Additionally, keeping a research journal was considered a helpful way to document on-going reflections during the research process and be aware of 'bracketing'¹² off certain assumptions that may have affected the research process.

Sampling

In accordance with IPA principles, it was important to aim for reasonable homogeneity of participants, using purposive sampling (Chapman & Smith, 2002). The specificity of the sample was ensured by identifying and recruiting participants that met the below criteria:

- Aged 18 years old and over;
- Identified themselves as previously or currently having an eating problem¹³
- Had accessed the charity MGEDT¹⁴.

¹¹ Reflections were recorded in the research journal.

¹² In IPA, 'bracketing' refers to putting aside prior assumptions and emerging ideas from the analysis (Smith et al., 2009).

¹³ Heterogeneity of diagnosis within this study's sample is defensible in terms of transdiagnostic conceptualisations of EDs (Fairburn & Harrison, 2003)

Written materials

A summary¹⁵ of the study was posted on the MGEDT website. This summary was also emailed to members of the charity. It was suggested that initial contact be made by MGEDT, rather than by the principal researcher. This would ensure that participants were aware of the study's legitimacy and its collaboration with MGEDT. This initial contact would also act as an appropriate opportunity to introduce participants to the aims and objectives of the study.

Members of the organisation who expressed interest in the study were advised to contact the principal researcher. An information sheet (including rationale, objectives and confidentiality precautions) was created by the principal researcher and the head of MGEDT.¹⁶ This letter was sent to interested participants and provided again at the point of interview. A consent form was created by the principal researcher and completed by the participants before commencing the interview.¹⁷

¹⁴MGEDT recognises that food and weight is not necessarily the problem, 'it is the embedded in the underlying factors which can be low self esteem and lack of self worth.' (MGEDT, n.d.).

¹⁵See Appendix 1 .

¹⁶See Appendix 2.

¹⁷See Appendix 3.

Research participants

In total, eight participants were interviewed (see Figure 1 for demographic and recruitment details).

Figure 1: Participant demographics and recruitment process

Participant ¹⁸	Age	Self-Identified 'ED'	Ethnicity	Duration of 'ED'
Mathew	52 years	'BED'	White British	1972-2012
Gerry	43 years	'AN'	White British	1986-2007
Arnold	22 years	'AN'	White British	2010-2013
Jonny	Missing information	'BN'	White British	1999-2007
Henry	33 years	'BED'	White British	1992-2013
Thomas	37 years	'BN/BED'	White British	1989-2007
Mark	32 years	'AN'	White British	Dates not provided but duration documented as 12 years
Frederick	40 years	'AN'	White British	1995-1997

Recruitment

Participants were recruited through the charity MGEDT.¹⁹ The head of the charity posted a summary of the study on the charity's website and also emailed those members for whom he had contact details. The members that expressed interest in the study were provided with details of the principal researcher and asked to make initial contact by email. Once the potential participant contacted the researcher, the researcher responded with an email thanking them for

¹⁸All names are pseudonyms for confidentiality purposes.

¹⁹The eighth participant was not recruited directly through the charity but had been informed of the study by a friend. He was included in the study as it was considered important to increase numbers in the study and it was not considered that the inclusion jeopardized the specificity of the sample.

expressing interest. It was ensured that the participant met the defined criteria before they were then provided with an information sheet (an extended version of the summary) of the study. Follow-up emails were sent in order to ensure that the participant had received the written material, that they were still willing to participate and to arrange the time and place of meeting with the principal researcher.

Data collection

Each participant attended semi-structured interviews for the purpose of data collection. Participants were interviewed at a location considered to be convenient in the local area (tending to be discreet areas within coffee shops). Prior to the interview beginning, participants were informed of the duration of the visit (approximately one hour). Additionally, questions based on the information sheets were asked to the participants in advance of the recorded interview, in order to ensure their understanding of the study. Finally, consent forms were given to the participants and completed prior to the interview.

Semi-structured interviews were selected as the most suitable method of collecting the data. The semi-structured interview allowed for the interview to proceed in multiple ways (in light of the participants' responses) and thus increased flexibility (Chapman & Smith, 2002). The interview schedule was designed to promote rapport and allow for empathy. The schedule also provided the opportunity to engage with respondents' areas of interest, which it was hoped, would result in a richer body of data (Smith, 1995). An interview schedule was memorised prior to the interview, based on published guidance (Willig, 2001; Smith, 1996; Smith & Dunsworth, 2003; Smith, 2008).

Drawing up a proposed schedule²⁰ beforehand allowed the researcher to identify key areas of interest and the focus of the interview to be outlined (Smith, 2008). The schedule's aim was to capture the men's journey through the development of the ED and beyond through covering four main areas:

- How the participants chose to describe their experience of the 'ED'
- What things were like during the course of the 'ED'

²⁰See Appendix 4.

- The experience of others during the 'ED'
- What things have been like in the process of seeking help for the 'ED' (or not seeking help).

A small number of open-ended questions were asked in the interviews (Willig, 2008), allowing the men's own words and comments to inform and guide discussions and ensure understanding. The schedule was considered as a helpful guide tool as opposed to a format to dictate the interview. The importance of allowing the participant to have a significant influence over the topics covered was ensured by designing the questions to be specific enough to encourage the men to talk about the topic in question, yet broad enough for them to cover the topics they felt were of key importance to them personally, with their own emphasis (Smith & Dunsworth, 2003). Prompts were included in the schedule particularly for the more abstract, open questions in order to facilitate responses and provide the opportunity for participants to have their own voices heard and tell their own unique story (Smith, 2008).

The schedule was revisited during the interviewing stage in order to identify particular questions and approaches that, it was felt, guided richer and more in depth discussion. The schedule was an organic document, to which minor adaptations were made as considered to be useful to encourage the participants' narrative²¹. The main changes included: preference of more personally relevant questions over abstract questions, more of an emphasis on the individual experience of the participants (including questions such as 'What was that *like* for you?'). Helpful techniques from past interviews were also recorded including the importance of using the participants' language and asking for examples.

The interviews ranged from 40 to 90 minutes, with an average duration of 60 minutes. Each interview was audiotaped using a digital recorder. Following the interview procedure, the participants were asked if they had any further questions, reminded to keep the information packs in case of use in future, and thanked for their participation in the study.

²¹See Appendix 5.

Analysis

The analysis requires both rigour and creativity (Whittemore, Chase, Mandle, 2001). It is well acknowledged that IPA is considered to be an approach (Smith & Osborn, 2003) as opposed to a particular technique and therefore the process of analysis relies on the combination of recommended strategies, in accordance with the researcher's personal style and the hallmarks of IPA.

Post interview, the researcher made observations of the context of the interview in the research journal.²² Interviews were usually transcribed within 24 hours of their completion.²³ The process of analysis began with the researcher becoming closely engaged with and immersed in the text. Once the eight interviews had been conducted and the interviews transcribed, each interview was analysed in depth individually (Smith et al., 2009). Each interview was listened to at least twice and several readings of the transcripts were carried out to ensure active engagement with the text. Initial notes of first impressions were made in the research journal. Re-reading of the texts also allowed for different narratives to be constructed and certain sections to be combined together, for example, chronological accounts provided one means of structuring interviews.

The initial stage of analysis involved the researcher exploring the descriptive, linguistical and conceptual comments of the text. A document was created for each participant with margins either side of the transcript²⁴. The margin on the left and right-hand side documented initial comments and possible emergent themes (Smith & Dunsworth, 2003). Once sections of the interview transcript were categorised into multiple and tentative themes, the same process was carried out with the next transcript until a point of saturation had been carried out with for each participant's transcript. Integretative analysis was postponed until each an analysis table had been created for each participant.²⁵

²²See Appendix 6.

²³See Appendix 7.

²⁴See Appendix 8.

²⁵ See Appendix 9.

After the initial analysis of each participant's transcript, the separate lists of potential emergent and superordinate themes were compiled into one standalone document. Various initial coding notes were also included in this document, identifying ideas for potential themes and line numbers (Smith et al., 2009)²⁶. This process allowed for the researcher to explore and consider the communality of themes across participants. In accordance with IPA principles, exceptions to more general themes that were emerging were acknowledged and highlighted.

The analysis process involved drawing on the description of identifying superordinate themes in Smith et al., (2009). Mind maps²⁷ were found to be a helpful means of making connections across cases and in considering the most potent themes. Quotations from each individual transcript were included in the different sections of the mind maps, ensuring that the emerging themes remained grounded in the participant's words.

Through the aforementioned processes, three superordinate themes developed representing shared higher order qualities. Data files were created for the three superordinate themes. Individual transcripts were revisited in order to identify the extract relevant to the three identified superordinate themes; both the transcripts and initial coding notes were consulted in this process. This allowed for the researcher to convey frequency of the theme both within and across participants. The identified extracts were read alongside one another in order to gain a shared sense of experience and identify subthemes. Key extracts were identified on the basis that they were considered typical, atypical of the theme, were metaphorical, emotional or seemed of particular importance (Smith et al., 2009). Finally, the table of superordinate themes was translated into a narrative account, where the themes were outlined, exemplified and illustrated with verbatim extracts from the participants (Chapman & Smith, 2002).

²⁶ See Appendix 10.

²⁷ See Appendix 11 and 12.

Validity and quality

Once the analysis had been completed by the principal researcher, the analysis was subject to validity checking based on guidance from Elliott, Fischer and Rennie (1999). This process included reviews carried out by peers. The review process included matching initial ideas generated from the data of potential themes with those developed by the researcher. The results of this process suggested that the themes had a high level of validity.

Ethical considerations

Prior to commencing the research, ethical approval was obtained from the University of East London (UEL) Research Ethics Committee²⁸. The National charity MGEDT provided permission to recruit from their database upon presentation of a copy of the approval letter granted by the School Research Ethics Committee. No ethical approval from any NHS research ethics committees was required, as the study did not recruit participants from any NHS settings.

Informed consent from the participants was obtained prior to each interview. This was to ensure that participants were clear about the rationale for study and what participation in the study would involve. Participants were made aware that they were able to withdraw from the study at any stage. They were not required to give a reason, nor would withdrawal disadvantage them in any way. At the end of the interview, all participants were given the opportunity to talk about the experience of being interviewed.

In accordance with the Data Protection Act (1998), all data were kept confidential participants remained anonymous. A password-protected encrypted flash drive was used to save all audio recordings and typed transcripts, which was subsequently kept safely in a locked cabinet for the duration of the research and destroyed upon completion. Once audio recordings had been transferred to the flash drive, they were deleted from the audio-recorder. At the point of transcription, it was ensured that all identifying information was removed. Names were not used on audio-material. Participants were assigned codes in order to identify details, which were kept locked away and stored separately,

²⁸See Appendix 13

and all participant data could only be accessed in full by the researcher. Anonymised data was accessed in part by the named supervisors and the examiners. All electronic data will be destroyed after five years.

Potential distress to participants

The researcher was conscious of the sensitive nature of the research subject and thus the potential for the participants to experience feelings of distress (Copperman, 2000). Where possible, efforts were made to minimise the potential for distress throughout. The researcher attended teaching on ethical issues in psychological research, both within University and at a separate IPA course. Supervision was an important space to reflect on interviews as well as re-consider and re-evaluate techniques to maximise development of rapport (Smith, 2008). The researcher had experience of managing distress in clinical settings, including with 'EDs' and male focused services. Participants were informed of whom they could contact if any difficulties arose, as a result of the research.

4. ANALYSIS AND RESPONSES

Interpretative phenomenological analysis of the eight semi-structured interviews resulted in the emergence of three superordinate themes, as follows:

1. Boys should be boys and men should be men
2. The experience of interpersonal relationships
3. The 'eating disorder' as both the problem and solution: Negotiating a road to recovery

Exploration of these superordinate themes and their constituent subthemes (see figure 2) will form the basis of this chapter, with each theme illustrated by verbatim extracts from the interviews.

Figure 2: Summary of superordinate themes and subthemes

Superordinate	Subtheme	Description
1. BOYS SHOULD BE BOYS AND MEN SHOULD BE MEN	1(a) Boys should be boys	The experience of oneself in boyhood was related to expectations of what it meant to be a boy and positioning within the ' <i>group of lads</i> '.
	1(b) Experience of Society's perception of men, bodies and 'eating disorders'	The experience of the media's increasing emphasis on men and their body shape was explored. The experience of society stereotyping 'EDs' as a ' <i>female issue</i> ' was spoken of in relation to restricted opportunities to discuss bodily or dieting concerns amongst peers.
	1(c) Experience of being a man and seeking help	Participants spoke about the experience of help-seeking in relation to powerful social constructs around what it means to be male and to be experiencing difficulties. Society's perception of eating problems as a 'woman's problem' led to internal self-doubt and increased isolation.
2. THE EXPERIENCE OF THE INTERPERSONAL	2(a) The impact of the 'eating disorder' on relationships with others	Living with an 'ED' was linked to increased isolation: this was considered to be both an active decision by participants but also an active choice of others to avoid them. Others had a powerful effect in terms of influencing the participants' sense of self. The incompatibility between having an 'ED' and maintaining interpersonal friendships

		was explored by all participants.
	2(b) The influence of others in seeking help	Others were considered crucial in acknowledging and identifying the 'ED' as a problem. Others provided validation and support, which were believed to facilitate the recovery process.
3. THE 'EATING DISORDER' AS BOTH THE PROBLEM AND THE SOLUTION: NEGOTIATING A ROAD TO RECOVERY	3(a) Punishment	The experience of the ED as a means to punish oneself is discussed in terms of both active self-harm and deprivation. The perception of agency in the act of punishment differed between participants. The motivation behind these acts was also explored by participants.
	3(b) Eating disorder as a means to achieve and stand out	Participant described the eating problem as providing them with a new sense of identity and feeling of achievement.
	3(c) The process of establishing a new sense of self and the difficulty of letting the 'eating disorder' go	Personal dilemmas of engaging in a process of recovery were considered. Finding value in another activity or project, in an attempt to re-discover former parts of oneself was considered important in the recovery process.

1. Boys should be boys and men should be men

The experience of gendered expectations and the effect on the individual was discussed by all participants. The first superordinate theme reflects data relevant to the research questions on (i) understanding of the development of the 'ED' in men and (ii) how men describe what it is like to have an 'ED'. Subtheme 1(a) describes how gendered expectations around what it meant to be a 'boy's boy' affected the participants' experiences of growing up. Subtheme 1(b) reflects the participants' experiences of societal expectations and perceptions around men, bodies and 'EDs'. Subtheme 1(c) conveys how gendered expectations impacted on the participant's journey to seek help.

1a) Boys should be boys

In this theme, as a boy²⁹, positioned identity and sense of self, was at least to some extent considered to have been controlled and regulated through expectations of what it meant to be a 'boy's boy' and the participant's positioning in the boyhood network. Not only had these experiences, particularly experiences of '*not fitting in*', affected the participants' sense of self at the time; they also resonated in later years with the adult psyche.

In this extract, Frederick demonstrates the connection between his current self-esteem and feeling out of place and unconnected to a boyhood culture in his childhood:

I know I have a tendency to struggle with my esteem you know...³⁰ I think growing up I was never a boy's boy. I wasn't interested in football and spent a long time trying to get into football... I was never part of that group of lads really...there's a huge pressure as boys really, all that conformity that goes on... is massive. (Frederick, L.217-225)

²⁹ It is acknowledged that these accounts are retrospective and that some of the terms and expressions reflect the understanding of an adult recollecting experiences as a boy.

³⁰ '...' Denotes words that have been cut out to ensure that excerpts are concise and clear; care has been taken not to alter participants' intended meaning in any way.

The account reveals the setting of parameters for acceptable and unacceptable ways of being a 'boy's boy'. Frederick highlights that despite him purposively 'trying' to engage in activities he felt were valued in the group, he had 'never' felt part of the 'group of lads'. The use of the adverb 'never' reflects the level to which he felt disconnected and unaccepted in the group. His use of the adjectives 'huge' and 'massive' emphasises the enormity of the pressure he felt to conform to the stereotypes of being a boy.

The repercussion of not conforming to a particular construction of gendered norms was that some of the participants were left feeling that they were a minority; that they were different; some even believed themselves less worthy. Later, Frederick makes connections between his experiences of other boys and believing that he was different:

At primary school, there was a, "I don't feel right", "this doesn't feel right" and "I can't fit in"... "I am going to try and like football. (Frederick, L.228-229)

When recollecting on boyhood, the participants placed emphasis on what the male body could *do*. The way in which the body *performed* had played a significant role in how masculinity was constructed and the perception of oneself and others. For example, as Frederick highlights above, participating in sport was an important domain associated with being a 'boy' and, despite acknowledging that they disliked this activity, some of the participants expressed the pressure they felt to 'change' and to re-shape themselves to fit into the mould. Some of the participants gave the sense that adopting what they considered to be a more masculine identity had felt unnatural and that they had felt that had to achieve more to reach an accepted level of behaviour in comparison to other boys.

The following extract indicates that some of Mark's conclusions about childhood times derive from his understanding and constructions of experience reached only upon later reflection on his childhood:

I've done a lot of therapy and thinking about it(L.48-49)...I didn't think they'd change, I thought I'd have to change...

found I was unacceptable or less acceptable than anyone else, that I had to do more to get to the same level as everyone else. (Mark, L.119-121)

Such stereotypes of boys were sometimes reinforced by male peers and often close family members. Thomas indicates:

I was a sensitive little boy... I wasn't some... big brash football player like my dad ... I already felt that I was fat and my parents had made quite a big thing of it... "you don't like playing football." I keep mentioning football because my dad is really into football... "oh you need to do more exercise" (Thomas, L.85-110)

In conjunction with the theme of being sporty and fit, some participants described their early awareness of their own body shape. The boy's body shape seemed to play an important part in the construction of his masculinity.

Here, Mark describes his awareness of his body shape and connects this to others' behaviours:

I was a little bit chubby, you know... and one of the slowest and things like that. You know, kids being kids, erm, you know, that gets picked up on. And I was picked as being different for that reason. (Mark, L.48-52)

Elsewhere, Mark speaks about 'losing weight' to 'satisfy [the other 'kids']'³¹. The word 'satisfy' alludes to the demands and expectations that Mark felt were placed on him in order to avoid being bullied. Similarly, Thomas recounts his experience of feeling 'bigger than the other lads' and links this to having 'massive' (L.311) issues around how he felt about himself.

Participants spoke about the link that peers had made between non-masculine associated behaviours and homosexuality: '*Erm I was considered to be effeminate, I wasn't really interested in boys things so I was assumed to be gay,*

³¹ □ Denotes words that have been added to ensure are clear; care has been taken not to alter participants' intended meanings in any way.

so lots of taunts' (Jonny, L.9-10). Failure in highly valued masculine domains could be linked to external and internal questioning of the individual's sexuality. Connell (1992) suggests that heterosexuality is another defining feature of traditional masculinity. For Frederick, his engagement in non-masculine behaviours was connected to emerging questions around his sexuality and later the development of eating difficulties:

And I remember going you know actually what I want to do is to sit and chat to the girls you know. But I remember distinctly going, well that's not what I should be doing. So there was always, ...you know, I guess, emerging sexuality stuff... that, then from about 4-5 to 19, having this huge disconnect really. "What's your gender?", "what's your sexuality?" and so that, for me, is linked to the eating stuff (Frederick, L.226-235)

Frederick uses terminology and expressions indicating an adult's understanding of issues that he encountered in his childhood. In his account, the use of rhetorical questioning highlights the confusion and uncertainty he felt about his sense of self for a span of fifteen years.

It is noteworthy that in many of the participants' accounts, despite experiencing powerful feelings of not fitting in or being able to make sense of their identity, there is a distinct absence of conversation around how they felt they were able to express these feelings or the opportunities they had to make sense of these occurrences.

In response to these difficult experiences, some of the men discussed increased isolation in the younger years to avoid bullying or being 'tormented'.

Jonny recalls feeling:

So isolated within myself, and at school. You know, I didn't have many friends... because I feared being accused, or being a given label which, myself, didn't know at the time... It became a complex mix of different situations and, erm, insecurities. (Jonny, L.47-51)

Jonny suggests that the only way to avoid internal or external attacking, related to his non-masculine behaviour, was to isolate himself from those who would be privy to the attacking behaviour. He describes the uncertainty he felt about himself and the concerns he had about others determining who he was by labelling him or putting him in a particular category.

Here, the experience of being a boy is explored, alongside the meaning that participants make of these experiences in adulthood. Being a boy was associated with needing to conform to certain masculinity domains, including enjoying sport and having a physically acceptable appearance (the latter often considered to be a corollary to being good at sport). The accounts convey the negative experience of not fitting into the stereotypical image of a boy and the individuals' efforts to counter these feelings by re-moulding themselves and engaging reluctantly in masculine-valued activities. Participants described the repercussions of demonstrating non-masculine behaviour, for example, being considered '*effeminate*', and men explored the associations that peers made between non-conformity to a masculine image and sexuality.

1b) Experience of society's perception of men, bodies and 'eating disorders'

Once in adulthood, participants reported feeling pressure to conform to a prescribed image of masculinity. Participants spoke about this pressure, both as being self-imposed by internalised concepts of masculinity and the need to adhere to these, and the increase in expectation that commercial greed and the media has fuelled over the past decade by displaying male models, with toned and muscular physiques (and the expectation that 'ordinary' males would conform to these).

Here, Henry describes the role of the media in perpetuating the problem:

I think the whole media image that's portrayed...guys are getting the same treatment with six pack ripped figures, sort of being what you should aspire to. (Henry, L.189-193)

Many of the participants acknowledged that, whilst, previously, media images had focused on the female body and '*size zero debates*', increasingly, certain magazines and media images were placing similar pressure on men. It is

interesting, however, that Mathew was an exception to this pattern and instead spontaneously and directly suggested: *'There's not the same um, anything like the same weight of media influence coming at the male society to say, you know, you should conform and be like this. It's almost just totally different in its nature'*.

For participants who *had* experienced an increasing pressure from the media, there were consequences. Thomas describes the impact:

There are men now getting completely obsessed with their body mass. (Thomas, L.1282-1283)

Arnold describes a similar experience: *'thinness and weight loss are such accepted goals in society'*. The paradox of an increased pressure to conform to a certain image of toughness and strength, yet it being considered unacceptable for men to talk about, or express any form of concerns around, diet or body image, is later articulated by Thomas:

In my experience there's a big difference, like, it's ok for women to talk about their diet and food and what they eating or not eating, but why would you be bothered, you're a bloke? It's this idea that you are not allowed to be concerned...(L.792-807) there is a big male elephant in the room. (Thomas, L.839)

Thomas highlights the mixed messages that men are given, from the media, peers and wider society around what is unacceptable and acceptable behaviour for a man. This intense frustration, of the perception that it was unacceptable to discuss body concerns and eating problems as a man, was reiterated by many of the participants.

Here, Thomas explores this issue further:

I don't know many of them [my straight male friends] that sit round over a pint that talk about how worried they are that they haven't been able to find a girlfriend in ages, because they feel like no-one would like them because they don't feel

attractive, or they don't feel...that they are a hot person.

(Thomas, L.830-836)

By setting the context of men talking '*over a pint*', Thomas provides an example of what may be considered 'masculine-appropriate' behaviour. This image is considered to be incongruent with the idea of men acknowledging their insecurities, talking about the desire to attract women. Similarly, Mathew speaks of the problem going '*back to the males, we ought to be able to sort our problems out for ourselves; 'We oughtn't to have to seek advice.'*' (L.224) It seems that Mathew has internalised ideas that seeking help is unacceptable behaviour for males. The use of the word '*ought*' seems to suggest that Mathew is very aware of an expected state as a male, and one is left wondering about the external forces that they may be responsible for imposing this expectation.

The feeling of being unable to discuss issues that were considered effeminate extended to participants and their ability to talk about 'EDs' specifically. Within the accounts, there was a central theme that 'EDs' or other problems were considered externally by society, and internally by the men, to be a 'woman's issue'. Frederick highlights that men only became aware of EDs '*through female celebrities*' (L.161)

Reflecting on society perceiving eating problems as '*women get it and men happen to get too*', Frederick proposes that:

It's easier for the general public to comprehend it as an over-exercise muscle thing.. (297) it's just an easier concept to grasp, rather than men making themselves sick or using laxatives...people don't want to think that actually it's messy... (Frederick, L.311-314)

Frederick suggests that society has a certain perception of '*men with EDs*' which they can '*grasp*' (L.311) and make sense of, at least to some degree, and that this perception precludes 'anorexic' or 'bulimic' behaviours.

In summary, this theme clearly highlights experiential dilemmas that the participants face in the expectations they perceive to be imposed on them. Many

of them felt an increased pressure to be *'built up'* and adhere to what they considered to be an unrealistic representation of being a man. They acknowledged that this pressure was intensified by the media and men's magazines. Despite this increased pressure, participants spoke clearly about the reluctance of men to discuss concerns around their appearance for fear that such behaviour would be classified as non-masculine. As such, similarly to experiences in childhood and adolescence, men did not feel that they had any role models in the media or in friendship groups within which to take guidance or with whom to confide.

1c) Experience of being a man and seeking help

The lack of conversation around men with 'ED' and the perception of 'EDs' as primarily a woman's problem had led many participants to doubt whether they had an 'ED' or not and, furthermore, had led them to experience shame around their body concerns and eating problems. The participants spoke about the experience of disbelief in others, that men were susceptible to 'EDs' too, as critically influencing their journey to help. Frederick describes the reaction of others to the possibility that men could get 'EDs':

*People find it difficult, they associate it with a female thing..
Probably a certain scepticism... What's going on?
(Frederick, L.282-284)*

Frederick continues to explore the impact this belief had on his own difficulties with weight and body image:

*There was nobody that I knew who'd, a man, who had a
problem with eating... it was a female thing. I wasn't even
sure that men got it... There were no role models... so
maybe then this is an abnormal thing...maybe this isn't what
I've got. (Frederick, L.112-116)*

Frederick's internal dialogue demonstrates persistent self-doubt around the possibility that he could *'maybe'* have an eating problem. The use of the present tense and the adverb *'maybe'* in the final sentence indicates that he still holds in

mind that, perhaps, he doesn't have an 'ED' and that what he experienced in the past, and perhaps, continues to experience is '*abnormal*'. The absence of others in the same situation led to a feeling that he was different, resulting in him finding it difficult to make sense of or express his difficulties.

The experiences of feeling '*abnormal*' reflect some of the participants' earlier experiences of not '*being a boy's boy*', further perpetuating a feeling of being different. With the experience of self-doubt seemingly exacerbated by social comparison, Frederick is led to wonder if he is '*normal*'. Similar to experiences in boyhood, some participants felt that because no-one overtly demonstrates behaviours or discusses thoughts diverging from the norm, it is only they who do, and therefore, that the behaviour is '*abnormal*'.

The participants suggested that the experience of feeling isolated and alone had negatively impacted on their ability or willingness to seek help or confide in others. Participants spoke about the isolating social consequences of having an eating problem, compounded by being a man with an eating problem. Gerry draws on the extreme comparative example of the experience being '*a bit like cancer*'. By making this comparison, Gerry alludes to the pain associated with being in this position. The comparison to cancer suggests that this problem may be experienced as having been imposed on him and that to some extent he lacks control over the outcome. He speaks of the reaction of others:

People don't know quite what to say and so they avoid you. (Gerry L.316-318)

This comparison demonstrates the potency of his experience and highlights that, despite the difficulties he faced, he faced them alone.

The theme of '*being the only one*' and '*abnormal*' was strongly connected with increased isolation. Gerry speaks of the consequences:

...you become very much of an outcast and locally you stick out, like a sore thumb. (Gerry, L.314-315)

Here, Gerry alludes to other's reactions to physical changes in his appearance and suggests that others don't know how to react and therefore end up avoiding

the individual. There is a sense that everyone without this problem is viewed as 'normal' or adheres enough to Gerry's or society's idea of normality. Downward social comparison, as a judgment of one's own self, is a strong thread throughout the participants' narratives.

Gerry gives the sense that people cannot handle the nature of the disorder, nor can they make sense of men having an eating problem. Similarly, Arnold said he didn't think that people would have *'joined the dots to think it was a disorder'*. Like Gerry, Jonny highlights the double stigma attached to being a man with an ED and the impact this had on his journey to help:

As a man that's going to reinforce the isolation that can really fuel those eating disordered behaviours because it is a very isolating disorder in itself ... As a man... you might feel like you are the only one; you really need that lifeline and that reassurance that you are not the only one...that you are one of many men out there. (Jonny, L.166-170)

The stark contrast of Gerry's comparison of being a man with eating problems as *'a bit like cancer'* (L312) and Frederick's sense (below) of being silenced and staying *'underground'* highlights the wide array of descriptions of experience within the dataset. There is a clear tension between feeling that, as individuals, they stand out as different and abnormal and yet that they are not given a voice to express these difficulties. Frederick speaks of the messages that men are being given:

At the moment they are getting the red light, you need a green light if it's ok to... but unless you get the green light, through internet, through health professionals, it's going to stay underground. (Frederick, L.590-593)

He expresses the difficulty to be *'open about when you are not getting messages that it's ok to be open about it'*. However Frederick also highlights the problems of not opening up and feeling *'you are perpetuating some shame based things about eating disorders'* (L.571). It could be argued that in this example, Frederick experiences the tension between society's expectations of

keeping his voice '*underground*', against his own internal voice that has acknowledged the need for someone to step aside from what is expected, give a voice to men with 'EDs' and therefore begin a process of tackling some of the shame associated with being a man with an 'ED'.

Some of the men spoke about a physical threshold³², which, once reached, led to others encouraging the men to seek help; there was an association between the physical state of an individual and the perceived need for them to seek help. For example, if the men looked well, there was an assumption that they did not have eating problems. Arnold wondered whether, initially, people's disbelief may have been connected to their assumption that women 'EDs' made more sense, considering (despite the growing 'gender equality' influence of men's magazines, etc): '*Society puts such value on the perfect, like the perfect women physically, like bikini bodies and stuff like that*', and thus, '*it might take a bit longer to really get to grips with men having an eating disorder*' (L.141-145)

There were varying experiences of seeking help between the men. Frederick highlights the shame associated with making this step:

And if I got to the doctor...What does this mean in terms of, you know... I need to bring in money or I need to be this strong man. (Frederick, L.429-431)

He emphasises the mismatch between acknowledging and discussing the problem and being perceived as a '*strong*' man consistently earning a wage. Therefore, Frederick alludes to seeking help as being non-masculine and '*weak*' behaviour. Speaking of his '*need*' to carry out certain activities emphasises the pressure he feels to perform as a man. Furthermore, it highlights the valorisation of health and he questions what it means to seek help from the doctor because of problems with his physical and mental health.

³² This theme is explored further in superordinate theme 2

Some of the men made an active choice to avoid seeking help from the medical profession. Gerry states that he would '*never go near the medical profession... although people wanted me to get help*' (L.274). The use of the adverb '*never*' perhaps exemplifies the finality of his decision, despite others encouraging him to seek help.

Similarly, Frederick says:

I didn't go to the doctor and I think that was very much about, it would have been about a man going to a doctor about an eating disorder...it was just not what you did. (Frederick, L.103-104)

Here, Jonny links his experiences of being unable to talk about difficulties to feeling that in doing so he would be engaging in non-normative or acceptable behaviour for a male:

As a man, you might feel like you are the only one-you really need that lifeline and that reassurance that you are not the only one...that you are one of many men out there (L.168-171)...but it conflicts the whole sort of masculine ideal of being strong and, you know, not really admitting to going through any issues 'cos that's seen as being slightly effeminate, you know, weak perhaps. (Jonny, L.345-348)

Some of the men did reach services but had mixed experiences. Mark presents a positive account. He acknowledges that others are wary of seeking help because of their gender: '*I know some are very big on this, on GPs not picking it up*' (L.457) but he continues '*I never felt disadvantaged because I was a man*' (L.459) In fact, Mark suggests that there were some advantages to being the only male in a group of females when he was admitted into in-patient care:

I suppose I could offer a different perspective, I didn't have the same fears... I think the staff valued it because they didn't get to experience it very often (Mark, L.432-436)

Mark's account differentiates the experiences of males with an ED and females with an ED based on binary ideas of gender but, unlike other participants who found this distinction burdensome, Mark stories it as an advantage. He suggests that, being a man, he did not have the same worries and was able to contribute to others' experiences. He conveyed this experience as being valuable. Here, Mark presents a positive experience of being a minority in a majority. This contrasts to his earlier experiences in boyhood, where he recalls:

I found I was unacceptable or less acceptable than everyone. (Mark, L.118-120)

He suggests that in this environment, not only was he acceptable but he was valued.

In summary, men found that society's perception of EDs as a '*women's problem*' led them to experience internal self-doubt and disbelief from others, hindering their steps to identify and acknowledge the problem. The lack of medial role models and others speaking of men with eating problems had led participants to feel that they were abnormal and become increasingly isolated. Some men felt that others would not be '*able to handle it*' or '*get to grips*' with men having an 'ED'. It is noteworthy that some men felt that their problem was only taken seriously when their physical appearance changed. The perception that men did not get EDs led individuals to keep their difficulties '*underground*' for a longer period of time. When men did seek help, their experiences were mixed.

2) The experience of interpersonal relationships

The experience of relationships was discussed by eight participants. The subtheme 2(a) explores the impact of the 'ED' on the individual's relationships with others. Subtheme 2(b) considers the influence of others in the individual seeking help for the eating problem. For some of the participants illustrating themes 2(a) and 2(b), the two themes were sometimes in a systemic feedback loop. The experience of the 'ED' leads to disruption of close interpersonal relationships; the close interpersonal relationships provide a stimulus for help-seeking; the experience of 'ED' begins to be resolved; the close interpersonal relationships begin to recover.

2a) The impact of the 'eating disorder' on relationships with others

The experience of isolation was sometimes considered to be imposed by others but, at other times, a decision made by the men:

I was just curled up on the sofa like an animal on display, you know? As soon as I got back I just wanted to be on my own sort of thing. (Mark, L.200-2003)

By comparing himself to an animal, Mark portrays a powerful image of being disconnected from the human world. The verb 'to *curl*' suggests a sense of vulnerability and wanting to protect oneself from those to whom he perhaps felt exposed. He wants to be on his own, but feels as though others are still looking at him, as in a zoo exhibit; curling up gives him maximum privacy from their gaze and allows him to be positioned in the womb-like comfort of the sofa. Mark portrays an experience of darkness and hopelessness, as he refers to his life with an 'ED', as like being in a 'box' for the rest of his '*life*'. The metaphor of a box again illustrates his lack of positive human relationships or connection with others and, instead, being enclosed in an all-encompassing world of darkness, with no escape.

Similarly, Thomas speaks of feeling '*disconnected from the world*' (L.456). As his problems continued, Thomas found that the eating problem impacted on romantic relationships to the point where he felt he could not sustain them. He

refers to a therapy session, where he speaks of his regret at ending a relationship during his time with an 'ED':

I remember the session where I said to her [therapist], "you know, I can't `believe I ended it with him, because I really liked him." (Thomas, L.599-600)

He explains that, in the relationship, he '*never got any time on his own, and then, of course, the next thing was to eat, when I wanted to. To have the choice of eating*' (L.418-420). Thomas suggests that his relationship with eating was incompatible with sustaining a romantic relationship and that, at the time, he prioritised his relationship with food. On reflection, he suggests a sense of disbelief and shock around his actions:

When I realised I was not seeing people, as in, someone who wanted to see me, specifically because it didn't leave me time (to eat)...it feels really fucked up... To think that somebody would choose food, over being in someone's company that you'd like... I find that really distressing. (Thomas, L.535-541)

Thomas's account exemplifies the extent to which he felt the 'ED' closed down other interpersonal relationships and, therefore, a significant part of his life. The use of the word '*distressing*' demonstrates the sorrow and pain he felt with his behaviour, which contrasted with a previously very sociable self.

Connected to their experiences of stigma and discrimination, some of the men also felt that others made an active choice to avoid them. Gerry suggests that '*people never come up to*' (L.405) him. He also acknowledges that, with the 'ED', he '*never went out with people to interact with people on the social side.*' (L.406-407) He later explains that, whilst he felt others were '*broadening their horizons, going to the parties...going out*' (L.98-99) he was feeling '*more withdrawn*' (L.197) and that life '*had to be like dark and life had to be painful and miserable.*' (L.101-102) The use of '*had*' suggests that his route had been chosen for him, imposed on him. The image of others broadening their horizons evokes a sense of increased light and openness. This image is in stark contrast

to Gerry and Mark's description of darkness, pain and the sense that something is closing in on them and perhaps closing down former parts of their selves.

For Gerry, he believed that his personality changed and that *'the whole enjoyment had gone from things'* (L.101) thereby forcing him into a life of darkness and loneliness. Similarly, Thomas describes a change in his behaviour to others:

Tiny slights by a friend would turn into massive grotesque arguments and I realise now... that loads of that was just feeling terrible about myself and not being able to say it.(Thomas, L.437-438)

Thomas connects a change in his behaviour to others with his experience of himself. Again he reiterates the distressing nature of such experiences, compounded by the feeling that he was unable to express these difficulties to anyone.

Despite vividly reporting experiences of loneliness and isolation, the men also discussed how others impacted on how they felt. Others were considered to have both a negative and positive impact on the men. Gerry spoke about the importance of others in affecting his mood. He says:

I got a real buzz when people were delighted with what you'd done. (Gerry, L.425)

On the other hand, he was alert to how he believed others might perceive him and how these perceived images restricted him in achieving what he hoped to achieve:

[I] love having fun with kids but, again, you know it's that hohah, single guy, not married, looking a bit weird, people aren't going to let me anywhere near their kids, so that broke my heart as well...and, to be fair, a lot of other sufferers are very giving people you know. (Gerry, L.371-373)

Gerry paints a picture of himself as someone unacceptable and inappropriate to others. He suggests that these restrictions '*broke his heart*' and therefore exemplifies the extent of the distress and sorrow he felt at his understanding that the image others held of him would inevitably restrict him from doing the things that he had once enjoyed. In mentioning that other sufferers are '*giving people*' too (L.375), Gerry challenges images he believes that society holds of people with an 'ED'. He seems to be making the assumption that people dismiss those with an 'ED' all too readily, but he emphasises that a label of an 'ED' does not define someone and their worthiness. Similarly, in Henry's account, he reports becoming very mindful of others' opinions and perceptions of him: '*What I was doing a lot of time... I was putting my opinion in people's mouth*' (L.518-519). He reflects on this awareness and suggests that, in hindsight, '*realistically I didn't have a clue what they were thinking, what they were talking about, even if they were looking at me, but it was that mentality that I had got myself into*' (L.523-525).

Gerry found others wrongly attributed characteristics to those with 'EDs' and Henry realised he had, perhaps, made wrong assumptions about others.

There was a strong theme throughout the interviews around others' disbelief at the participants' eating problems and the implication these reactions had on the experience of relationships. Jonny reports:

They were quite surprised when I said I was a young lad with bulimia... "oh really that's new". (Jonny, L.151-153)

He suggests that this concept was a novelty to people and these reactions made it '*very difficult to relate to other people how I was approaching the problem*'. Again, the author is alert to the experience of feeling lonely. Men felt that even family members held doubt around their problems:

...even now, some family members don't believe that [I have an eating problem]. (Henry, L.120)

Despite having '*gone through the process (seeking help)*' and feeling that he '*can now confidently see that it's not a problem*' (L.307). Henry suggests that family members even now hold some doubts around him having an 'ED'. Henry

alludes to a belief that, despite the progress he has made, he cannot change others' perceptions of his eating problem.

Many of the men felt that they could not confide in others for fear that they could not '*handle*' or would not believe their difficulties. The all-encompassing nature of the difficulties meant that, for many of them, part of their identity, or a significant part of their lives, had to be kept underground, thus making it very difficult to develop and maintain friendships.

2b) The influence of others in seeking help

For some men, their families were the first to acknowledge the severity of the problem and encourage them to seek help (Arnold: *'well primarily my family, er, it was my mum who just, like, sat me down and talked through it with me.'* (L.39-40) Mark similarly conveys the role of others in acknowledging the severity of the problem:

...but when my home, my mum, saw that, as I say, I had lost a stone and a half since she'd last seen me, the look on her face then, that's when I probably knew it was serious...they couldn't get me home quick enough. (Mark, L.185-187)

Here, Mark speaks of the physical changes in his appearance as indicating the gravity of his problem. Mark suggests that being away at university had allowed the problem to progress. Similarly, although Gerry is not specific about who wanted him to seek help, he acknowledges that others *'encouraged'* him to *'go and see people'* (L.224). For Frederick, it was prompts from his family that led him to make changes. Again, one alerted to the importance of the physical representation of the disorder as being key in alerting others to the problem:

It was actually my sister that introduced some change into my patterns of eating. Yeah they kept saying "we're really worried", and I was ridiculously thin... a lot of the family were going "we're really worried" and I went "I know what I'm doing". (Frederick, L.125-129)

This extract emphasises the importance of physical indications (as opposed to psychological cues) of distress as being key in others becoming concerned about the individual and encouraging them to seek help.

Despite mentioning the importance of others in reaching help, men also made it clear that the recognition that others wanted them to seek help was not always enough. Gerry explains that whilst:

...people wanted me to I guess seek help.. you get very alienated very quickly...because nobody knew about it, nobody locally, specifically not a guy. The first thing you see about somebody is what you see, isn't it, and that is the first reaction... I don't mind people looking back but when I catch them staring.
(Gerry, L.298-303)

The role of appearance is conveyed by participants as being crucial to how they were perceived and perhaps even judged by others.

The importance of validation from others and ongoing support was a poignant theme throughout the accounts. Gerry highlights the role of consistent support in order to deter the eating problem:

...again, I think you've got to try and support people continually, try and say "I believe in you, you can do it" and "you can come back from the other side." (Gerry, L.1352-1355)

In emphasising the significance of others' support, this extract alludes to the encouragement that Gerry yearned and hoped for but did not receive. Throughout the accounts, there has been a clear theme of stigmatisation associated with increased isolation and disconnect from the real world. It is, therefore, perhaps not surprising that validation and listening from others were considered to be key elements in the recovery process. The men's accounts powerfully illustrate the influence of simple and emphatic responses of others in the process of recovery. There were different elements to the importance of speaking with others. For Jonny, it was the opportunity to speak openly and anonymously:

Speaking to people anonymously alleviated some of the isolation and secrecy around what you're going through.
(Jonny, L.253-254)

Similarly, Frederick valued the opportunity to be open with people:

Its about just listening, you know... I think a lot of issues get better when [you] create a relationship with someone, and you feel that you can talk about stuff openly...letting go of stuff is massively helpful. (511-514)... People just need [to] ...feel it's alright to talk about it... If it's approached in a non-judgmental, caring way, people will respond (Frederick, L.589-590)

For Frederick, he felt comfortable exposing who he was and appreciated the opportunity to develop a relationship with someone. He highlights the simplicity but the powerfulness of people feeling that, *'it's alright to talk about it'*. His experience is in stark contrast to some of the men's experiences of feeling closed down and silenced.

Mark experienced the importance of others within an in-patient setting. He describes how his initial apprehension around being *'stuck with nine other people'* and having *'no choice'* were changed when he *'suddenly talked to people'* and realised *'they are not actually that bad'*. He continues to speak of the contrast of this experience to past experiences of feeling that *'everyone was just waiting to take the piss out of him'*. Mark explains:

It was the first time, as I say, in ages that I had just been able to sit down and speak to people and not feel that I had to off and run... (L.311-313) I really kept my distance from people at university... I was too scared to expose myself.
(Mark, L.318)

In this extract, one is alerted to the significance for Mark of re-engaging in what might seem quite 'normative' behaviour (i.e. sitting down and talking to people) in an environment where he felt safer and more comfortable than he had previously.

Wanting to change for others' sake was considered to be an important motivating factor in seeking help. In the extract below, Mathew speaks of the real change occurring when he realised the impact that his eating problem was having on his son;

...The major switch and trigger.. was, erm, that my elder son was at school and was showing some real signs of going the same way(L.103-105)...I am convinced that it's the motivation, the motivation to encourage him, was actually the bigger motivation for me than to do it for myself (Mathew, L.119)

Similarly, Gerry speaks of the power of changing for others:

Not wanting to let somebody down.... that was bigger than the eating disorder itself. (Gerry, L.792)

Participants were less likely to discuss the significance of change being self-motivated. One is left wondering whether they believed they were deserving of a different and better life (without the 'ED') and whether there were parts of the eating problem that they did not necessarily want to let go. The sense of not wanting to let the problem go is explored in later themes.

In summary, relationships with close family, therapists and wider society were crucial in the process of seeking help. Relationships with others and the awareness of the impact of the problem on others was often viewed as the key motivating factor in making changes to behaviours associated with the eating problem. Furthermore, in contrast to earlier experiences of stigmatisation and discrimination, men spoke warmly of experiences of validation and comfort when seeking help and the value they placed on these moments in the recovery process.

3) 'Eating disorder' as both the problem and the solution: Negotiating a road to recovery

The theme of the eating problem as both a problem and a solution and the difficulties and successes in negotiating a way to recovery was very clear in six of the eight transcripts. Interview analysis of the remaining two participants found extracts that clearly exemplified one or more of the three sub-themes. It is noteworthy that the extract material underpinning the third theme is mostly gender-neutral. Subtheme 3(a) reflects the concept of the 'ED' acting as a means to self-punish or be punished. This was sometimes viewed as a helpful means to process emotions and at other times something the participants had no control over. Subtheme 3(b) considers the men's description of the function of the 'ED' to stand out and succeed at something. Subtheme 3(c) is concerned with the advantages and disadvantages of having an ED, and, particularly, the participants' ability to negotiate a road to recovery.

3a) Punishment

Self-punishment was a strong theme throughout the men's accounts.

Both Gerry and Frederick discuss the experience of loss in childhood as being key in the development of the eating problem. In Gerry's account, he speaks of feeling that self-punishment was initially the 'right' (honourable) thing to do; carrying on enjoying life was unjustifiable and his nan's death deserved more than to be forgotten in the onrush of life:

My nan dies...I do remember at that age sort of [pause] not really accepting the fact, or being a little confused at the fact that the rest of the world was going on as normal...the shops opened, turn the telly and the same programmes still on...your world imploded... I remember feeling that I couldn't justify just going on and enjoying life...So, if I was suffering, somehow it was easier to deal with what was going on. (Gerry, L.32-39)

The account clearly recalls Gerry's experience of loss and bereavement. It seems significant that Gerry speaks in the present tense, perhaps suggesting

that the suffering continues. For Gerry, there was a powerful and sudden change in the way he perceived and understood the world. There is a sense that he held a helicopter view of the world as he continued to witness things going on as '*normal*' around him, yet felt that his world had shattered in front of his very eyes. He felt that he was undeserving of carrying on as normal and that a functional response was to induce suffering in himself as a mechanism to '*deal with what was going on*'. Gerry describes intentionally inflicting pain on himself because the only way he could '*justify sort of being alive, in a way, once someone had died, was either being miserable or in pain*'. He clearly describes running having not eaten and says '*it hurts*'. He describes this '*pain*' as something he adjusted to that is ongoing and inevitable:

You'd become used to hurting inside, almost like a gnawing pain. (Gerry, L.73-74)

For Henry, he attributes his '*destructive behaviour*' to his parents splitting up and the resulting issues of feeling abandoned and, similarly to Gerry, there is a sense of loneliness in his account. One is again drawn to consider the feelings of loss experienced by Henry as his perception of his parents and his family is transformed at such a young age:

My parents split, when I was around about three... so, just old enough to remember the arguments...it was also feeling abandoned... it sort of snowballed from there. (Henry, L.63-74)

Henry's use of the phrase '*just old enough*' adds to the pathos, arousing pity/sorrow for the author.

Jonny discusses bullying and instability in childhood as being key precedents to the act of punishment through purging. He suggests that there was a multitude of factors connected to his sense of needing to punish himself:

It really began when I was eleven because I was really badly bullied from day one at high school ..(L.7-9) it crossed into

being, sort of more aggressive and violent...and then over time it became a regular habit, going to the toilets..I used to make myself sick which was entirely intuitive...(L.17-18) It was a culmination of different pressures for me...it was the bullying, an unstable home life. Some form of instability and this was a way of coping (L.137-139)... ... (Jonny)

The use of the word '*intuitive*', suggests that Jonny viewed this form of self-punishment as based on how he felt, rather than conscious reasoning. Henry also mentions the loss of control associated with his destructive behaviour, therefore suggesting that acts of punishment were not in his conscious thought and, by suggesting that he cannot '*see it*', he alludes to an external invisible force over which he has no control. He calls the behaviour of bingeing and purging a '*red mist descending*'. The description evokes images of a cloud approaching and disturbing or blocking the individual's sense of clarity and clear conscious thought and the colour indicates aggression. Henry suggests that the control is taken out of his hands and this episode or behaviour is almost imposed on him:

You know what you are doing is destructive behaviour...(158-159) ..It's actually losing control and not being able to see it. (Henry, L.181)

With regard to Thomas, he describes the act of punishment during university. In his account, there was a suggestion that the act of self-punishment was something of which he was conscious. At the time, he normalised the behaviour assuming that this was a common response to feeling low:

I was really depressed and very erratic, really punitive with myself. I didn't, kind of realise at the time, I just thought that was how everybody was with themselves...And my way of punishing myself was through food and through the purging behaviours that I had. (Thomas, L.56-62)

Similar to Gerry, Thomas connects his low and unpredictable mood to this behaviour. However, in contrast to other men's accounts, Thomas presents less

of a sense of feeling alone or abnormal in connection with being *'punitive'* with himself.

Whilst Gerry primarily mentions the act of punishment as something that he controls and something he has chosen to engage in, later in the interview (when referring to the progressive nature of the 'ED') he draws the conclusion that he must have done something wrong and, therefore, deserves to suffer. He compares the problem to being like *'cancer'*. This metaphor suggests, perhaps, that, at this later stage, the *'punishment'* was out of his control. Thus the data presents the paradoxical experience of punishment as both self-imposed, and externally imposed.

Mark's description of the punishment as *'horrible and constant'* reiterates the circular nature, suggesting that there is a lack of hope. His description suggests that he has no agency on the nature of the disorder and that there is no escape:

It's horrible and constant..you don't see an end..you learn to accept that you are going to be in that box for the rest of your life. (Mark, L.15-18)

Again, with Mark, there is a sense that the punishment is imposed on him and that he lacks a sense of agency. By acknowledging that the ongoing punishment associated with an ED determines *'every decision you make'*, he suggests a sense of enclosure and lack of choice or free will.

Whilst active punishment was a clear theme throughout the text, the act of depriving oneself was also mentioned as a form of indirect punishment. Gerry describes the denial of pleasure:

Life had to be, like, dark and life had to be painful and miserable always (L.101-102) ...You know, denying myself anything and everything and everything, and it was more than just food I denied myself . I denied myself any pleasure... you know, or if I saw something in town, "that's really nice", I wouldn't buy it. Why? Why are you justified in, unless you've done something, you know, to deserve it, it was a whole, like, just persecuting yourself really (Gerry, L.237-242)

The act of avoidance had previously been considered in relation to a response to bullying and allowing the individual to become increasingly isolated. Here, one is given the sense that denying happiness and contentment is more a form of punishment. Gerry suggests that, not only did he deserve to be punished, he also deserved to be denied anything that he did not feel himself to be worthy of. As a result, he extends this deliberate deprivation to other meaningful areas in his life.

In summary, the acts of punishment associated with 'eating disordered' behaviour was experienced via two main threads: self-denial and, secondly, self-punishment (which also feels externally imposed). The men presented the idea that self-punishment came about as a response to instability and a need to gain better control over their environment. Within the accounts, there was a clear variation in the men's experiences of their own agency in the act of punishment. Within the men's accounts, descriptions convey the sense of men both taking on the role of being punished and at other times being the punisher. In other extracts, there is a sense that something more powerful and external is punishing them, resulting in an experience over which they have no control.

3b) Eating disorder as a means to achieve and stand out

Overall, the participants spoke about experiencing the benefits of developing and maintaining an 'ED'. Participants described controlling the eating problem as a means of feeling a sense of achievement. Thomas says:

So all of this time I would be exercising, but then the more I got successful at controlling how many calories I was taking in, the longer I could sustain that. (Thomas, L.125-256)

Describing himself as 'successful' emphasises the profitable nature of gaining control and being good at something. Frederick goes as far as saying that he 'loved' the feeling of losing weight. He continues to say that he has always been inclined to comparison. Arnold also articulates the eating disordered behaviours as a means to feel some form of accomplishment:

It wasn't necessarily to lose weight, but to try and see what I could do. Like, how far I could push it. (Arnold, L.16-17)

However, for many of the men, there was a sense that the quest for feeling a sense of achievement was short-lived, resulting in feelings of needing to strive for more, to do better. Gerry exemplifies the experience of being on a continual pursuit to achieve more:

*I starve myself, and if I'm existing on that much, and when
I'm existing on that much, I'll push myself a bit further and
push it this much. (Gerry, L.284-285)*

Gerry takes responsibility for being in control of this problem. He speaks in the first person, acknowledging that he continued to push to get a '*bit further*'. Frederick shares this experience of losing weight as being a means to achieve something:

*[I was] in a perpetual state of wanting to achieve
something...I got a great buzz from it. (Frederick)*

The noun '*buzz*' suggests that Frederick felt a sense of euphoria in being successful at something. However, his later description provides a stark contrast:

*It's some kind of Greek myth you know, Atlas holding up
the world, some on-going torture that you can't get out of
and that you don't want to get out of because it's your thing.
(Frederick, L.269-271)*

The metaphor of Atlas³³ can be interpreted as Frederick feeling that he has been condemned to suffer on-going torture by a more powerful and external force from which he is unable to free himself. This enforced role is all encompassing. It is possible that the associated highs he experiences mean that he cannot '*get out*' and, even if he could, he would not want to.

It is interesting that Frederick refers to the eating problem as being his '*thing*'. He alludes to the eating problem as being something close to him, and something that makes him unique. In previous parts of his account, Frederick

³³ According to Hesiod's *Theogony*, Atlas was one of the Titans who took part in their war against Zeus, for which, as a punishment, he was condemned to hold aloft the heavens.

spoke openly about his tendency to social comparison. It may be suggested that this is an area in which he feels he can be the best and therefore he provides an account, which reminds the author of the almost addictive nature of the problem. For Frederick a solution is found in the problem.

In Mark's account, he also documents the significance of the eating problem in providing a means to achieve, stand out and be unique:

I think that's part of wanting to stand out with my weight, to stand out by being fitter than everyone...my one real achievement was being thin. (Mark, L.122-124)

Mark links this desire to stand out and to excel at something as being related to his early experiences of being tormented for his appearance. These experiences had led him to believe that he was less acceptable than everyone else and that he would need to do more to reach the same level of acceptability:

I was picked out as being one of the biggest in school and one of the slowest...I thought: "I'm not going to suddenly get new eyes and I really don't want to start pretending to not be good at school just to satisfy them and so I thought, well I can lose some weight. (Mark, L. 56-59)

Mark perceived changing his weight as something that would add value to his sense of self. He suggests that he was not willing to give up other elements of his character; however, he felt that changing his weight would be enough to keep 'them' away. Here, there is not only a sense that Mark felt the need to achieve and be good at something for his own sense of self but also that he needed to be successful himself to affect others' perception of him:

I think it's still linked back to the bullying and wanting to be acceptable and being scared that if I wasn't thin, then there was nothing about me, nothing appealing to anyone...what an eating disorder lets you do is protect you from anything that's dodgy. (Mark, L.227-231)

It is interesting that Mark suggests that the one of the benefits of developing an 'ED' is its ability to shield away anything that he considered to be unwanted. The ability of the 'ED' to be protective is in striking contrast to Mark's description of the problem as *'it's horrible and constant'*. Here we witness the dilemma of being enclosed in the 'ED' 'box.' There is almost a tug of war between the gains and losses associated with the 'disorder', perhaps, contributing to the delayed time to seek help.

For Mark, the 'ED' became intertwined in to his sense of identity. He speaks of other's acknowledgement of 'anorexia' being part of him:

People started saying... you're anorexic and stuff like that and that felt brilliant .. I started taking on the role of being an anorexic. (Mark, L.60-62)

By taking on this role, Mark plays a certain character and has a way of being which is associated with positive feedback. This is particularly significant for Mark as this is a feeling he felt was lacking in his earlier years. He describes this new feeling as *'brilliant'*. The gains for some of the men included a new sense of self and a label and identity which they felt was unique enough to make them worthy of others' approval. Thomas shared this experience of the ED becoming part of his new-found identity:

I wanted to know more about it, you know be some kind of fitness expert...people were always complimenting me on how I looked. (Thomas, L.217-218)

For some of the men, they suggested that the 'ED' was very personal to them, helping them out during the day when they experienced negative feelings. Whilst men acknowledged the shame and secrecy associated with feeling that they were the only man with an eating problem, the secrecy and uniqueness of being the only man with an 'ED' also left some men feeling that, at times, they had a special relationship or attachment that no one else knew about. Jonny speaks of this experience:

...it was something very personal to me, it was my coping mechanism. (Jonny, L.114-115)

The 'ED' was something that men felt they could rely on when things were not going well or when they needed an outlet to process negative emotions.

Similarly for Frederick:

*...no real outlet for the process of bereavement for example,
so no one to do that with, so it got really stuck and then
eating was a great way, not eating rather, was a great way
of supplementing that (Frederick, L.198-200)*

As has been mentioned briefly in connection with the subtheme of 'boys should be boys', from a young age many of the men had a sense of being inadequate. For some of the men, controlling one's body shape and '*getting fitter*' was a way to stand out and achieve more than others. There is a sense that the ED became their '*thing*', their attribute, and therefore allowed the participants to develop a different, and for some a more valued identity, during an uncertain and unstable time.

3c) The process of establishing a new sense of self and the difficulty of letting the eating disorder go

The previous sub-themes (3 a) and b)) have demonstrated the personal dilemmas faced in the development and maintenance of the 'ED'. Mark was one of two participants admitted to an in-patient ward in an attempt to 'cure' his eating problem. He recollects the initial fear of agreeing to engage in treatment:

*It just seemed more and more scary to let it go (L.196).
Being thin...it was the one thing that [on the ward] didn't
distinguish me from anyone else. (Mark, L.281-282)*

Whilst Mark has previously noted the benefits associated with being the thinnest and therefore being the best at something, in this environment, for the first time, he did not gain value from being thin. He continues: '*So suddenly you have to bring a bit of your own personality and it's just amazing*'. (L.284-285) In handing over the control of his weight gain to the hospital Mark told himself that, '*I haven't got any choice in here*' (L.291-292) he felt less guilty that he was not controlling his weight. He continues:

*I think that it was just the first time, as I say, in ages that I had
just been able to sit down and speak to people and not feel
that I had to go off (L.310-312)...it was just, the first time I was
able to Mark out from behind the anorexia, and see the
reaction I got from people when I did that. (Mark, L.324-325)*

Mark had spoken openly about the fear of exposing himself and the role 'anorexia' had played in providing him with a mask identity. He clearly demonstrated both the gains and losses associated with acquiring this role. However, for him, it was not until he inevitably lost this role and point of difference that he felt he had no choice but to rediscover and expose other elements of his character. His account suggests that, in slowly removing the mask of 'anorexia', he was surprised and encouraged by the positive response of others. Therefore, whilst Mark felt he had lost his uniqueness within the ward, he had also gained back part of his former being. The re-emergence of former facets of his personality and the positive feedback from others gave him a sense of hope:

...your life doesn't have to be like this...but it was the time to see that (l300)...The good feeling I got from everyone was enough to keep me going. (Mark, L.296-297)

For Gerry, running the marathon became a key part in the process of recovery. This new goal was significant for a number of reasons. In a similar way to Mark, he found that concentrating on a new goal provided the opportunity for people to view him externally to the label of 'anorexia'. He recalled:

After running the marathon...people were interested in me now. (Gerry, L.1239)

Gerry suggests that this revelation was almost unexpected and that he had '*transformed things in some respects*'. In completing the marathon, Gerry describes having '*done things that, you know, I'd never been able to taste before*', and labels this achievement as, '*the first thing I had achieved in my thirty years, erm, and I guess other people recognised me slightly.*' Whilst Gerry had mentioned being '*good at sport*' and the '*oyster boy*' in his younger years, there is a sense that these achievements were not good enough and that the marathon had finally given him a chance to stand out and be accepted. For Gerry, the '*buzz*' and '*highs*' of having an 'ED' had been replaced by the excitement, thrill and the taste of being the only one locally to run the marathon:

Hardly anyone locally had run a marathon... So actually they thought: "Whoa, you've done something". And, of course, you get such a buzz and you're on such a massive high (Gerry, L.883-885)

Gerry speaks of others '*actually*' thinking "*you've done something*". Gerry spends time describing the impact this event had on the ways other perceived him and there is a sense that, for Gerry, this was the most significant part of this accomplishment. The impact of achieving something that he believed others to value affected the way he perceived the world and his own happiness:

You appreciated everything so much more, as well, because every bit of happiness, you thought “how precious”...Every now and then I was getting emails, would you do this interview... so I started to talk a little bit more. Get a little bit more confident I suppose. (Gerry, L. 149-154)

As a consequence of the marathon, Gerry finally felt that others wanted him to talk and were not afraid to hear what he had to say. He speaks of the confidence this gave him. He believed people had transformed his story from one of being the only man with an ‘ED’ to being a man with an ‘ED’ who had turned his life around:

I think it’s the thought that, actually, somebody might find a way out because you’ve said something or you’ve proved that you can beat it. It’s massive, you know (Gerry, L.1399-1401)

Both Thomas and Jonny spoke about the difficulties of ‘giving up’ the ‘ED’. For Jonny, he felt that he was giving up a part of who he was. However, Jonny found new and alternative ways to develop a stronger sense of identity, drawing on parts of his character which had perhaps been masked by the enduring and all-encompassing nature of an ‘ED’. Here, he speaks about becoming involved in volunteering with people with ‘EDs’:

I didn’t tell everyone [publicly] ... I did get involved in different projects and volunteering, which helps. It kind of validated what I went through. It helped me realise that, actually, in a weird way there were some reasons why I went through what I went through and there’s benefit at the end because actually it’s made me a stronger person (Jonny, L.211-214)

It could be argued that Jonny experienced a form of post-traumatic growth. Not only did these experiences validate and normalise what Jonny had been through, he suggests that there are benefits to be drawn from going through adversity and coming out the other side. Mathew describes similar aspirations: *'One of the things I am looking to do potentially is to do quite a lot of distance coaching on this'* (L.193-195) For Jonny, these benefits were feeling that he was stronger in himself; for Gerry, he felt more confident and, for Mark, he felt that he had re-connected with former parts of his character.

Henry suggested that the 'ED' had provided him with an outlet for negative emotion and he began to write a blog to document these experiences:

What I've actually found through creative writing that I am doing and writing the blog, a coping mechanism for me, being able to deal with some of the more negative emotions (Henry, L.509-511)

Within this superordinate theme, the men have mentioned the role of the eating problem in helping to develop a new and more valued identity. On the other hand, the eating problem has also been seen as a means to self-punish by physical, self-harming behaviours (such as purging) or the denial of food and any source of enjoyment. Overall, the eating problem was considered by participants to have become a key part of their identity, affecting their lifestyle choices and their sense of self. Reflecting on the significance of the eating problem in the men's lives, it is perhaps no surprise that they experienced hesitation and resistance in the process of recovery and shedding this part of them. Within this theme, the process of recovery is explored in terms of the difficulties associated with no longer having an 'ED', but also in terms of the new and improved outlets and identities that men found in the process of letting the 'ED' go.

5. DISCUSSION

The aim of this study was to gain an in-depth understanding of men's experiences of living with and seeking help for an 'ED'. This chapter pulls together the final themes that emerged following interpretative phenomenological analysis of the eight participants' accounts.³⁴

This chapter discusses the three main themes of 'boys should be boys and men should be men', 'the experience of interpersonal relationships' and 'ED' as both the problem and solution: Negotiating a road to recovery.³⁵ The first theme reflects the significance of the construction and enactment of masculinity, spoken about at an individual, interpersonal and social level. The second theme captures the experience of deteriorating relationships in the context of the ED. The significance of others in the help-seeking process was also widely reported. Central to the final superordinate theme is the paradoxical nature of experiencing an 'ED': the 'ED' provided a new identity and yet also acted as a means to punish oneself and be punished. Possible connections between the themes are also explored. The study is evaluated based on Yardley's (2000) criteria. Lastly, methodological limitations and ideas for future research are outlined.

Boys should be boys and men should be men

This subsection addresses the first area explored in relation to the research questions: participants' understanding of factors contributing to the

³⁴ It is acknowledged that it is important to be careful in drawing conclusions from this mixed sample, both in terms of the range of diagnoses and the difference in duration of the 'ED' amongst the participants. While there is evidence to suggest there may be some cross over in symptomatology and experiences between the diagnoses (Fairburn & Harrison, 2003), it is also recognised that participants were presenting with a variety of eating behaviours including purging and restricted eating, and therefore conclusions across diagnoses should be made tentatively.

³⁵ Unless otherwise stated the experiences are common across all identified ED diagnoses

development (and maintenance) of the 'ED', men's experiences of others' during the 'ED' and, finally, participants' experiences of seeking help for the 'ED'.

Firstly, there were early experiences of conflict, in terms of childhood failure to succeed in achieving society's pressure to reach 'maleness': boys (as individuals) ought to measure up to being 'boys' (as a standard). For some of the participants, engagement in non-masculine behaviour had resulted in internal and external questioning around gender and sexuality. Many of the participants vividly experienced themselves as having fallen lamentably short, in terms of action (sporting prowess) and appearance (body shape): *'Never a boy's boy'; 'less acceptable than anyone else'; 'I wasn't some big brash rugby player like my dad... I already felt that I was fat.'* These experiences were distressing and disorientating for the participants, leading them to feel *'different'* from their peer group. The experiences elicited different responses: some participants described attempts to re-mould themselves in order to *'fit in'*, while others described themselves as becoming increasingly isolated.

This theme reinforces literature suggesting that from a young age boys are alert to what it means to be male (Kearney-Cooke & Steichen-Asch, 1990; Drummond, 2001) and that achievement, involvement in sport and often physical attributes of the body associated with being 'sporty' become significant markers in improving boys' popularity and social standing (Ricciardelli, McCabe & Ridge, 2006.) In extension to previous literature in this field, this study explores the retrospective accounts of adults (in the UK) who have identified as previously or currently having an 'ED' and their current understanding of experiences in boyhood, in relation to the enactment of masculinity and body image.

The participants shed light on the profound consequences of such experience on their sense of self and in their experience of relationships, both as boys and as resonating with the adult psyche. For one person, the negative experiences led him to detach and become increasingly isolated as a strategy to limit the prospect of bullying. For others, not fitting in had resulted in an

increased awareness of masculine norms, the need to adhere to these and thus a growing fixation with their body shape and involvement in sporting activity.

Secondly, the trajectory of experiencing failure to measure up to the prescribed male 'standard' continued into adulthood but, although participants expressed a growing adult capacity to express themselves, there was no ready outlet to do so. This finding corresponds with Grogan and Richard's study (2002), which found that adult males had restricted opportunities to talk about body/weight concerns. The accounts of participants distinctly described the experience of feminised stigma around dieting and body image concerns at an individual, interpersonal and social level. These findings provide insight into the effect of external constructions of 'EDs' as a '*female problem*' (such as those documented in the McVittie et al. (2005) study on male students' attitudes to 'AN'). The findings are particularly significant as such experiences may impede recognition of symptoms, awareness from others and the route to seeking help as a male.

Thirdly, the foregoing factors established a trajectory of experiences for the participants: (i) failure to reach prescribed 'male' standards, (ii) the development of habitual responses (including problems with eating) to this shortfall, and (iii) the silencing of men talking about these difficulties, given the stereotype of 'EDs' as a female phenomenon anyway. It is not surprising, therefore, that seeking help was not only difficult to access, but was experienced as a strange and unfamiliar territory amongst participants.

The accounts provide rich descriptions of both participants who sought professional help, and of those who were either unaware of specialist help or rejected such invitations. The findings support and extend the work of Copperman (2000), who found that a lack of awareness in the public arena for all types of 'ED' hampered men's ability to recognise and seek help for 'EDs'. The findings can also be understood in light of the literature that men are more likely to seek help for behaviours they consider to be normative and common to other males (Mahalik et al., 2003). The assumption that there

were no other males in the same position perpetuated ideas experienced in boyhood, that the individuals were '*different*' and that they did not adhere to the archetypal view of being male, leading to isolation and deterioration in relationships.

In connection to the previous two subthemes, it may be argued that feeling '*different*' perhaps exasperated early awareness of powerful constructions of masculinity. In turn, these experiences may predispose such individuals to a heightened awareness to media images and constructions of masculinity, which additionally may impact on their experience of seeking help.³⁶

Implications and Recommendations

These findings support the contention that the construction of gender is experienced at an individual, interpersonal and social level (Drummond, 2002). The study reinforces the need for a broader psychosocial perspective to fully understand the meaning of masculinity and its relationship with the body within men's lives across the lifespan (Drummond, 2002).

The participants' accounts support a growing body of literature that from a young age, boys identify with male norms, and that sport and weight are often implicated in developing a self-concept (APPG report, 2013). It is noteworthy that only in adulthood did participants feel able to express and voice these concerns. At a broader level, the recent APPG report emphasises the need for a preventative approach and suggests that schools should provide compulsory lessons to equip young people with the tools and resources to challenge unrealistic aesthetic images. Drawing on the finding that men recounted these experiences as being most influenced by peers and parents, it seems important that systemic interventions are adopted in order to broaden the focus from the individual and incorporate the wider context in which these problems are situated (Carr, 2006). Such interventions should aim to extend the awareness of gender issues and body image concerns as legitimate problems for males across the lifespan.

³⁶ This hypothesis is provided tentatively and it is acknowledged that further research is needed to add weight to this possible explanation.

In designing such interventions there is a need for important consideration of the content, applicability and relevance of the devised intervention. Whilst it is acknowledged that cultures manifest traditional masculinity in different ways, there are overlapping themes of power, restricted emotional range and competition found across culture. The visibility of the gendered body in boys' experiences of school suggests the importance of taking into consideration experiences of being big and small and of feelings of strength and vulnerability, and of encouraging males to explore how their attitudes, beliefs and behaviour are reflected and felt in their bodies (Blazina & Shen-Miller, 2011). Additionally, the study reinforces the importance of professionals being alert to the impact of uncertainty around gender and sexuality propelled by taunts from peers. In terms of applicability and relevance, whilst the men's accounts within this study often adopt binary distinctions between female and male, it is important to remember that perceptions of how a man should act and behave may be affected by other areas of 'difference', for example, race or disability.

The findings highlight the importance of providing a diverse range of approaches to help men with 'EDs'. It also seems of paramount importance that services have a greater focus on the accessibility and availability of psychological services for males. The findings suggest that at an individual level, it may be important for psychotherapy services to target troubling gender-specific socialising experiences that may be linked to the onset of an 'ED' in males. Participants expressed the difficulties of being unable to talk to peers and feeling as if they are the only male with an ED, thus the introduction of male self-help groups may provide men with the opportunity to share their experiences with other males in a similar position.

At a professional level, the provision of training courses specifically focusing on men and EDs are an important means of alerting professionals to this increasing phenomenon. The study suggests the importance of professionals acknowledging that men may be more reluctant to voice concerns over a problem highly associated with females. Therefore, within initial consultations, there is a requirement for greater focus around sensitively asking relevant and

appropriate questions to facilitate men's ability to express these concerns.

At a social level, BEAT (BEAT, n.d) and MGEDT (MGEDT, n.d.) have been particularly prominent in promoting awareness of EDs in men. Participants clearly articulated the need for increased awareness around men and EDs in the media (particularly an increase in male celebrities with EDs becoming more prominent) in order to reduce the feminised stigmatisation associated with bodily concerns.

The development of a National network for men with 'EDs' may be an effective means of collating and synthesising research. This could also facilitate collaborative research to move the field forward, raise the profile of men with EDs and effectively disseminate relevant information and publication.

The experience of interpersonal relationships

This subsection addresses material related to two of the stated research questions: the experience of others during the 'ED' and how men describe what it is like to have an 'ED'.

The impact of the 'eating disorder' on relationships with others

Whilst literature in the female 'ED' field has considered the role of relationships, especially within the family (Hill & Franklin, 1998), there is a paucity of quantitative and particularly qualitative research focusing on the impact of the 'ED' on current relationships and the development of new relationships. Research into the impact of the 'ED' on men's relationships is limited to one recent study, which employs a quantitative approach and confirms that men with 'EDs' tend to have fewer social relationships (Mangweth-Matzek et al., 2010). The qualitative approach in the current study allowed for further exploration of the impact of the 'ED' on relationships with males.

Overall, there was a clear sense that the 'ED' negatively impacted on interpersonal relationships and had led the individual to feel increasingly isolated. The all-encompassing and relentless nature of the participants'

relationship with the 'ED' had left little room to develop and maintain social relationships (Thomas- *'I was not seeing people...specifically because it didn't leave me time'* (L.535))³⁷ Furthermore, the 'ED' had resulted in a changed sense of priorities and interests and, in turn, distanced the participants from social aspects of self. The participants spoke about behavioural changes that inevitably affected the continuation and compatibility of relationships (Gerry- *'if you're not going to go here, or if you're going out somewhere and you say no, no, no, at the end of the day you won't get asked will you'*). The mutual interests that may have once driven relationships had been taken over for the participant by a new and significant interest, the 'ED', and, as such, the ED was discussed as a deterrent to being sociable and also as a means to reduce the expectation of others in the social arena.

A negative sense of self (influenced by social comparison and the experience of others) was described by participants as beginning in boyhood (theme 1a) and continuing into adulthood. Gerry spoke about his awareness of how others perceived him (*'single guy, not married, looks a bit weird'*). Thomas described feeling *'terrible'* about himself and the effect this had on his behaviour towards others. The participants' accounts corresponded with theories of the sense of self suggesting that the experience of self is influenced most by interactions with others, negative and positive (Mead, 1934; Striegel-Moore, Silberstein & Rodin 1993). The findings from this study support literature on females, which suggest that individuals with 'EDs' predominately hold a negative view of themselves, often influenced by their experience of others and sometimes resulting in increased isolation (Brooks, LeCouteur & Hepworth, 1998). The Self-Regulatory Executive Function model (S- REF; Wells & Matthews, 1996) may be drawn on in explaining this pattern. For example, negative self-perceptions are viewed as more threatening, and so they may occupy more processing resources, and thereby reduce the ability of participants to attend to and integrate more positive views of self. However, in adulthood, there also appears to be a close link between a negative sense of self, experiences of isolation and the theme of

³⁷ In Thomas' account he emphasises the need for time to carry out purging behaviours

stigmatisation articulated in the first superordinate theme. It seems unlikely that such theories (locating the problem within the individual) adequately account for the participants' experience of stigma and shame associated with the 'ED'. The distress and shame associated with 'EDs' may be explained by how devalued people feel by the labels or derogatory opinions, which are powerfully imposed on them by society (Dallos & Draper, 2005).

The Influence of Others in Seeking Help

Previous literature has highlighted the importance of becoming aware of the contexts in which men are influenced to seek help (Mahalik et al., 2003). This superordinate theme sheds light on contexts that facilitate the help-seeking process in men. Particularly, one is drawn to the role of others in raising concerns, acting as motivating factors and in providing a non-judgemental response to the 'ED'.

Participants' accounts suggested that physical indicators of the disorder had been key in raising concerns in others, as opposed to psychological and behavioural changes (Mark- *'But when my mum saw that as I say I had lost a stone and a half since she'd last seen me, the look on her face then, that's when I probably knew it was serious' (l.185-187)*). This is an interesting finding for two main reasons. Firstly, it suggests that the layperson may be more likely to hold a disease-model representation of 'EDs' and be less well attuned to behavioural or psychological indicators of 'EDs'. Secondly, it is possible that males (compared with females) exhibited less alarming physical deterioration until later on in the progression of the disorder. The latter explanation is in line with the hypothesis that whereas women strive for thinness, men aim for muscular shape (Weltszin et al., 2005; Muise et al., 2003).

The importance of close family members in facilitating the help-seeking process links to literature emphasising the role of social supports in recovery (Rorty, Yager, Buckwalter & Rossotto, 1999; D'Abundo & Chaly, 2004). However, it is interesting and noteworthy that participants referred less to the role of peers in encouraging the help-seeking process. Mahalik et al. (2003) notes that a man who is surrounded by a supportive group of other men that

encourage members to share problems and seek support might be more likely to seek help than a man whose only social network neglected such sharing. It is possible that the lack of visibility of peers in the help-seeking process is related to the restricted opportunities for men to feel justified in speaking of non-normative behaviours, for example, dieting or considering bodies in aesthetic terms.

The importance of others providing support, encouragement and a non-judgemental approach was found to be crucial in the participants' willingness to engage in the help-seeking process. Whilst literature consistently emphasises the importance of validation (Laing, 1983), it is possible that this experience was even more powerful for these participants, many of whom had contended with multiple forms of stigma (Corrigan, 2004). The stigma and disbelief³⁸ from others had been internalised by the individuals, thus emphasising and explaining the relief of coming into contact with someone who believes in the individual, listens and provides hope (Thomas - *'I think a lot of issues get better when [you] create a relationship with someone, and you feel that you can talk about stuff openly'*).

Implications and Recommendations

This section clearly emphasises the detrimental impact of the 'ED' on relationships and, on the other hand, the importance of others in facilitating the help-seeking process for males with 'EDs'.

For some participants, it was only post therapy or in beginning the process of recovery that they had become alert to the effect that the 'ED' had on relationships. This finding emphasises the importance of speaking to others in order to story and understand interpersonal experiences connected to the 'ED'. Interpersonal psychotherapy has been identified as an effective means to address EDs (Fairburn, 1992). It is possible that the restricted opportunities in which males feel justified in talking about their problems (Drummond, 2002) may further exacerbate the impact of 'EDs' on relationships and so this maybe another important aspect to address in therapy.

³⁸ Highlighted in subtheme 2

The participants tended to feel they should be ashamed of their problems because of the double stigma associated with this experience; these experiences resulted in men feeling isolated. In the process of therapy, it may be important for the model and approach to consider that isolation becomes seen as a safe place. Providing an accepting therapeutic environment is essential to an individual's self-acceptance and vital in developing a sense of belonging in a society that isolates him for being different. In addition, it will be vital to re-assess how counseling is presented to men as this has been found to affect men's engagement with therapy (Drummond, 2003).

ED as both the problem and the solution: Negotiating a road to recovery

The final superordinate theme conveys the personal dilemmas associated with the experience of the 'ED', acting as both the problem and the solution. This theme addresses the research aim of exploring how men described what it is like to have an 'ED'. The extracts within this theme were susceptible to a deeper more interpretative level of analysis. The data seemed more experiential, and less rehearsed and descriptive. Additionally, in contrast to the previous two themes, the recovery stories were mostly gender-neutral.

Punishment

Mead (1934) suggests that the body, like all significant objects, can become a convenient screen on to which one projects one's most intense concerns. This superordinate theme addresses one way in which participants' inner concerns seemed to be projected on to their body. Punishment was described both in terms of denying oneself pleasure³⁹ (including food) and in terms of inflicting active punishment on oneself (for example, through purging and vomiting)⁴⁰.

Literature in the 'ED' field has suggested that traumatic events in childhood can predispose an individual to an 'ED'. In particular, within the male 'ED' literature there is awareness that bullying can lead to low self-esteem and body image issues (Copperman, 2000; BBC, 2013). Many of the men had

³⁹ The active denial of pleasure was more apparent in the accounts of participants who identified as being 'AN', as opposed to engaging in 'BN' or 'BED' behaviours.

⁴⁰ This behaviour was more prominent in the accounts of those who identified as having 'BN' or 'BED'.

recounted being bullied in their younger years. Participants described becoming increasingly isolated and the body becoming a screen on which they projected their most intense concerns (Mead, 1934). A possible interpretation of this finding is that the participants took control of the psychological and physical pain they endured from others and became their own punisher.

In this study, Gerry powerfully articulates the connection between a traumatic life event and the desire he felt to punish himself: *'so if I was suffering, somehow it was easier to deal with what was going on...you're burning inside.'* Whilst Gerry demonstrates a conscious awareness and decision to punish himself, other participants had suggested that the punishment began as an active choice (Jonny- *'it was aggressive'*) but later became *'intuitive'*. The sense that the punishment was being imposed on the participants and driven by an external powerful force was seen across 'ED' diagnoses.

ED as a means to achieve and stand out

Research has shown that individuals with 'EDs' are particularly motivated by a need to gain social approval (e.g. Striegel-Moore, Silberstein & Rodin, 1986). Mark's account supports Bruch's (1973) description of 'AN' as *'a desperate struggle for a self-respecting identity'* (pg. 250): *'I think it's still linked back to the bullying and wanting to be acceptable and being scared that if I wasn't thin there was nothing about me, nothing appealing to anyone'* (l.227-229). For Thomas, becoming an *'expert in fitness'* (and thus achieving a muscular physique) was an alternative means to changing himself and achieving social approval.

The findings indicate that negative trauma (as a result of significant bereavement or being bullied) may have a negative effect on self-concept (e.g. Beck et al., 1979; Vitousek & Hollon, 1990; Fennell, 1998; Young, Klosko & Weishaar, 2003). For most of the participants, the desire to stand out was linked to feeling *'unacceptable'* and inadequate in childhood. As illustrated in theme 1 a) the emphasis placed on sport (and as a corollary to that, having a 'sporty' body) had perhaps led to individuals to use the body as a means to create significant change in their identity and gain social approval for others

(*'someone said you're anorexic and stuff like that and that felt brilliant'*). Whilst others had a positive influence on self-perception, this was not always positive in terms of the consequences for the participant's 'ED'. The reinforcing effect of praise for slenderness and self-control has long been recognised as a perpetuating factor for the 'ED' (e.g. Branch & Eurman, 1980; cited by Polivy and Herman, 2002).

The benefits of the 'ED' are described as offering a temporary solution, resulting in a continuous quest to receive more praise, experience more highs and become better at having an 'ED': *'I'll push myself a bit further and push it this much'* (Gerry). This observation is perhaps connected to the participants' feelings that the ED is a *'really vicious cycle'* (Frederick) and the 'ED' is presented as almost addictive in nature.

The process of establishing new sense of self and the difficulty of letting the 'ED' go

Within this theme, participants describe the personal dilemmas that they encountered in weighing up the problems and exploring solutions in developing and maintaining an 'ED', and finding a way to let the 'ED' go.

Within the accounts, over half of the participants spontaneously spoke of the importance of helping others in the process of recovery. For Henry, Jonny and Mathew, finding ways to articulate their experiences and to again use part of their identity (as a man with an 'ED') in a constructive way to help others, was seen as an important step in recovery. Jonny and Mathew's participation as volunteers helped them to validate their experiences and find benefits in engaging in the process of recovery. For Henry, setting up a blog provided the same release. These strategies had encouraged the participants to engage with others that had shared a similar experience, perhaps relieving them from experiences of stigmatisation and isolation.

There was also a sense that actively achieving something or taking up a new interest was an effective way of empowering individuals to move forward in the recovery process. Gerry exemplifies the need to achieve something that no-one else had (running the marathon) in order to be valued and to give

back. By taking on the marathon as a goal, Gerry initiated a dramatic shift from being someone who was defined by an 'ED' to someone who had taken on a task, which had not been achieved by anyone else in his village.

Implications and Recommendations

The accounts suggest the importance of a new focus when finding other means to develop and strengthen one's sense of self. For many of the participants, it was important to find hope in the process of recovery and re-story parts of their experiences as being positive in terms of how it had enabled them to develop. The variety in the participants' approaches suggests the importance of creativity and finding a unique approach for each individual in the recovery process. Approaches may involve volunteering or re-engaging with a hobby (for example, art or creative writing). Family, peers and services may play a role in facilitating this process.

The implications of this finding further highlight the importance of focusing interventions on a negative or fragile sense of self which may be a result of internalised criticism from peers or a sense of instability triggered by a significant life event (such as parental divorce or bereavement). The results reinforce the importance of interventions aimed at improving self-esteem and elaboration of the person's sense of self (Fairburn & Harrison. 2003). However, this study also suggests that more attention needs to be given to gender issues implicated in the formation of a negative self-concept.⁴¹

Evaluation of qualitative methodology

There is now considerable discussion among qualitative researchers about the assessment of the quality of qualitative research (Smith et al., 2009). Yardley (2000) has provided four broad principles for evaluating qualitative research.

- Sensitivity to context
- Commitment and rigour

⁴¹ This suggestion has been elaborated on in the first section of the discussion.

- Transparency and coherence
- Impact and importance

This section considers how this study meets the criteria offered by Yardley. The above sections have considered the impact and importance of the present research and therefore this section will focus on the three remaining criteria, interpreted within IPA's epistemological and ontological context.

Sensitivity to context

Sensitivity to context can be demonstrated through an awareness of existing literature, the socio-cultural context in which the study is situated and, most importantly, sensitivity to the collected data (Yardley, 2000).

I have endeavoured to demonstrate these aspects in the introduction chapter by situating the research in the appropriate theoretical contexts, identifying relevant studies, gaps in the literature and by outlining theory underpinning the research method respectively. The findings have also been discussed in relation to relevant literature in the discussion. The exploratory nature of IPA allows for the discussion to include a dialogue with literature, which was not necessarily mentioned within the introduction section (Smith et al., 2009).

Sensitivity to context is also demonstrated within the data collection process. I remained conscious to the possibility of a complex powerplay in the meeting between research expert and experiential expert. With this in mind, I was very aware of the interactional nature of an interview (therefore recognising the importance of ensuring that the participant felt comfortable) and attuned to feelings that lacked neutrality (Ahern, 1999). Furthermore, during the interview process I documented the family and social context as well as significant life events for each participant in order to consider the data in relation to broader-level meanings and contexts.

In the analysis stage, it was important to be aware of prior assumptions (documented in the research journal) and to ensure that I did not privilege accounts that were consistent with these particular assumptions or my particular interests, in the process of selecting themes. I have aimed to

demonstrate sensitivity to context through conducting detailed case-by- case analysis and supporting selected themes with a number of verbatim extracts, thus giving participants a voice in the project (Smith et al., 2009).

Commitment and Rigour

The research sample has been carefully selected to match the research questions. Whilst the sample attempts to be reasonably homogenous (Smith et al., 2009), different types of 'EDs' have been included in the sample.⁴²

Rigour was demonstrated in the interview process by ensuring that I acquired a position between closeness and separateness (Smith et al., 2009). As a novice researcher, I chose to attend an IPA course, which focused on interview skills within an IPA interview. This training and regular supervision ensured that rigour and consistency in the interview approach⁴³ were demonstrated at both the interview and analysis stage.

Commitment and rigour were demonstrated in the idiographic approach adopted for this research. I ensured that each case was considered individually and that a holistic view of each case was constructed before progressing into the cross-analysis stage. The data analysis conveyed something of each participant's account. In staying committed to the IPA approach, exceptions in the data have been acknowledged rather than either being incorporated into existing themes or discounted.

Both peer supervision⁴⁴ and supervision with my research supervisor were important opportunities to ground myself and remain committed to the epistemological and ontological underpinnings of IPA. In these meetings, I

⁴² This was considered to be justifiable because of the increasing controversies around the current classification system (Fairburn, 2003) and IPA's emphasis on ensuring that research is not restricted by categories.

⁴³ The interview approach refers to the amount of probing used, picking up on important cues and delving deeper (Smith, Flowers & Larkin, 2009)

⁴⁴ A group of eight trainee clinical psychologists met up on a number of occasions to discuss the underpinnings of IPA, to present one's research and acknowledge assumptions affecting the neutrality of the work.

questioned prior assumptions around the subject matter⁴⁵ and how these may have the potential to affect my experience within the interviews, and in engaging with data analysis. Identifying my reactions of disappointment or surprise when data did not fit with my prior assumptions and discussing these within supervision allowed me to question and challenge these reactions and ensure that the data (as opposed to my assumptions of the subject matter) guided the analysis process.

Transparency and Coherence

Transparency and coherence are demonstrated by ensuring that the methodology section documents a clear and detailed account of participant selection, the interview process and the analytic stage.⁴⁶ Furthermore, coherence was ensured by attending closely to the experiential domain of participants. I have been careful not to make assumptions about the data and only tentatively offer possible and multiple hypotheses and linking theory, remaining consistent with IPA's approach as an inherently interpretative activity.

Reflexivity

Ahern (1999) provides helpful guidance on using reflexivity to identify areas of potential bias and strategies to 'bracket' these assumptions to ensure that their effect on the research process is minimised.⁴⁷

Part of the reflexivity process involved unearthing my own assumptions about men, attending to my own values and biases. Based on previous clinical experience with males and the finding that some of the participants in the study had avoided seeking professional help, I initially assumed that the participants may be reluctant to tell their own stories or expand on the more emotional aspects of their stories. On reflection, it is interesting that literature on males and their reluctance to talk about problems is often demonstrated

⁴⁵ Recorded in the research journal

⁴⁶ See Methodology Section

⁴⁷ See Appendix 6

when participants are in a process of seeking help or voicing concerns about their problems (Copperman, 2000). The interviewing process brought a different opportunity, in which the participants were encouraged to tell their own story (and on their own terms)⁴⁸: notably they explored not only the painful experience of having an 'ED' but, also and mostly towards the end of the interview, they spoke of restored hope and powerful stories of recovery.

I was mindful of feelings of anxiety, enjoyment and surprise during the interview process. For example, I was aware of the research questions' focus on the experience of having an 'ED' and so when participants wandered from this focus, I felt the pull to guide them back to this research aim. In reflecting, I was able to question reasons for the divergence from the main topic. I considered the role of my interviewing skills in keeping the focus. However, I also reflected on the potential challenges participants may have encountered in telling their story (many of whom who had not had this opportunity before). On the other hand, I was aware of the fact that participants may want the interviewer to be aware of other parts of their lives, rather than providing a problem-saturated account of their life. It was important in the interview to provide men with the opportunity to detail other parts of their lives post 'ED' and much of this material was incorporated into the final theme of negotiating a road to recovery.

Part of the process of reflexivity involved questioning whether assumptions based on my gender, appearance, and status as a doctoral student may have influenced how participants responded to my questions. The assumptions may have arisen as much through our similarities as our differences. I was aware that many of the men in the interview had not chosen to seek professional help and I wondered how my professional status was viewed and what had enabled them to tell their story in the context of this research study.

Limitations to the study

The IPA approach recommends selecting a reasonably homogeneous sample. It may be argued, based on DSM-V definitions of EDs (DSM-V,

2013), that a drawback to this study is the heterogeneity of identified diagnoses ⁴⁹included within the sample. On the other hand, the heterogeneity of diagnosis within this study's sample is defensible in terms of trans-diagnostic conceptualisations of the 'EDs' (Fairburn, 2003). Furthermore, the finding that there were several consistent themes between the accounts and self-identified eating problems provides further support for the idea of trans-diagnostic processes. Based on findings that men with 'EDs' 'do not access services and are reluctant to seek help (Copperman, 2000), from a practical point of view it was important to maximise the opportunity to recruit a sample of eight participants.

In designing the interviews, it was important to 'bracket' pre-conceptions. The interview should be designed to maximise the opportunity for participants to be able to make their own claims and voice their own concerns (Smith et al., 2009). It is acknowledged that the interview schedule inevitably had some effect on the themes that emerged in the analysis. However, careful efforts were made to avoid the use of leading questions, use the interview schedule flexibly and, therefore, adapting the questions used to respond to participants' answers. In addition, participants were provided with an opportunity to add any additional information at the end of the interview. Furthermore, the use of an interpretative method ensured that the themes were grounded in the words of the participants themselves.

Another consideration regarding the validity of the results is that the sample includes interviews from males who felt able to tell their story and reported being in a process of recovery. It is perhaps an interesting observation that there was a lack of participants coming forward who considered themselves still to be in the more serious stages of having an 'ED'. Therefore, the accounts of the experience of having an 'ED' are predominately retrospective. Furthermore, half of the males in the sample had sought professional help,

⁴⁹ While most of the participants had been given a formal diagnosis by a professional, the remaining participants identified themselves as having a particular diagnosis based on acquired knowledge and information from others.

which may have contributed to particular participants being able to provide a more coherent narrative, explanation or formulation of their 'EDs'.

A possible drawback to the study is that all of the participants (who provided their ethnicity) identified as being white British. It is important to acknowledge the culture specificity of this sample and remain cautious when drawing conclusions from a very culturally select sample. The finding that there is a possible link between the construction of masculinity, the perception of the body and the development of 'EDs', further highlights the need for future studies to include participants from a number of different cultures and backgrounds. Connell and Messerschmidt (2005) argued that masculinity is constructed and reinforced by a number of contextual factors including race and ethnicity, globalisation and transnational interactions. Furthermore, research suggests that the development and perception of 'EDs' may be experienced differently within and between various cultures (Boisvert, 2012). Conclusions from this very culturally specific sample must therefore be drawn with caution and future research should focus on drawing a more diverse sample, in order to gain a greater understanding of the role of culture in the development and maintenance of 'EDs'.

In the process of developing an interview schedule, it was decided not to ask about the participant's sexuality. The decision was informed by drawing on IPA principles which emphasise the importance of interviews being guided by the participant, allowing for the participant's own account of the experience to be explored (Smith, 2008). The downside of this decision was that not exploring sexuality directly with the participants the study has restricted the opportunity to utilise an exploratory approach to voice the participants' own experiences of the possible link between sexuality and their experience of having an 'ED'. It will be important for future research to explore this link further in order to gain a greater understanding of this possible connection and in order to contribute to literature in this field.

Future Research

Future research would benefit from exploring eating problems in men across different cultures. The field of 'EDs' would benefit from exploring the role of

culture in the development, maintenance and perception of 'EDs'. The current study has illuminated the significance of the construction and enactment of masculinity in relation to men's body image. In particular, it would be interesting to consider the ways in which masculinity is constructed and perceived in various cultures and whether this is connected to men's relationship to their bodies across and within culture.

While this particular study provided an opportunity to contrast the experiences of those who had and those who had not sought help, future research may concentrate on interviewing larger samples of the sub-groups within this group, to further explore differences and similarities between these two populations. If funding permitted, it would be valuable to conduct a longitudinal study beginning in boyhood following into adulthood in order to further understand the impact of experiences of being a male and how this is implicated in the development of 'EDs'. It is acknowledged, however, that the identification of such participants, the recruitment, and consent, would be challenging.

In future research, it may be interesting to evaluate the trans-diagnostic models of 'ED' by exploring the experiences of males who identify as having different 'ED' diagnoses. While trans diagnostic models suggest that there is an overlap in the presentation and aetiology between diagnoses, it is also acknowledged that there can be significant differences in the presentation of, for example, 'AN' (categorized by restricted eating) and 'BED' (characterized by eating large amounts of food and a short period of feeling out of control). Such research may identify whether certain themes are implicated more in specific diagnoses.

This study clearly highlights the importance of interpersonal factors in the development and maintenance of 'EDs' in males. There is a paucity of research focused on this area, especially within the male domain. Research would benefit from focusing on the other side of the relationship: professionals, peers and families. For example, what are professionals' perceptions of men with 'EDs'? How would a family respond to a male member developing an 'ED'? In the school environment, do adolescents/

teachers believe that males can develop 'EDs' and if they do, how could they respond? There are many unanswered questions focused on the interpersonal domain. The answers to such questions may be vital in order to gain a more holistic understanding of the development of and treatment for men with 'EDs'. Furthermore, research exploring the use of language in describing 'EDs' in males compared to female, adopting a discourse analysis approach, would provide an interesting insight into the role of language in terms of constructing social perceptions of 'EDs' between gender.

The current study suggests that further research is needed around the relationship between engagement in non-masculine domains, the experience of sexual identity and the later development of eating problems. Future research would benefit from utilising an exploratory approach to specifically consider possible links between participant's experiences of their sexual identity and the development and maintenance of eating problems.

Conclusion

This study aimed to provide an in-depth and idiographic approach to the exploration of the unheard voices of men in their journey of living with an ED, in an attempt to illuminate key aspects of their stories in a clinically useful way. The accounts reinforce the importance of considering the development and maintenance of 'EDs' at an individual, interpersonal and sociocultural level. The present study sheds light on some of the critical issues confronting men (at different stages of their lives) and the relationship of these issues with constructions and expressions of masculinity and to the development of 'EDs'. The participants' accounts strengthen the case to consider the role of gender and how the psychology of men and expression of masculinity affects the lives and process of help-seeking in men.

REFERENCES

- Abraham, S., & D. Llewellyn-Jones. (2001). *Eating Disorders: The Facts*. Oxford: Oxford University Press.
- Addis, M.E., & Mahalik, J.R. (2003). Men, masculinity and the contexts of help seeking. *American psychologist*, 58, 5-14.
- Ahern, K. J. (1999). Ten Tips for Reflexive Bracketing. *Qualitative Health Research*, 9, 407-411.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition, Text Revision*. Arlington, VA: American Psychiatric Association.
- Andersen, A.E. (1990). Diagnosis and treatment of males with eating disorders. In A. Andersen (Ed.), *Males with eating disorders*. (pp. 3-7). New York: Brunner/Mazel.
- Andersen, A. E. (1992). Eating disorders in males. In R. Lemberg (Ed.), *Controlling eating disorders with facts, advice, and resources* (pp. 21-28). Phoenix: The Oryx Press.
- Anderson, A. (1995). Eating disorders in males. In K. D. Brownell & C. G. Fairburn (Eds.), *Eating disorders and obesity: A comprehensive handbook* (pp. 177-187). New York: Guilford Press.
- Andersen, A.E., & Holman JE. (1997). Males with eating disorders: challenges for treatment and research. *Psychopharmacological Bulletin*, 33(3), 391-7.
- APPG. (2012). *Reflections on body image: all party parliamentary group on body image*. Retrieved April 6th 2013, from <http://www.ymca.co.uk/bodyimage/report>.
- Baum, A. (2006). Eating disorders in the Male Athlete. *Sports Medicine*, 36 (1), 1-6.

- BEAT (2008). BEAT annual review. Retrieved July 27th 2013 from:
http://www.b-eat.co.uk/index.php/download_file/view/90/120/
- BBC News (2013). *Boys suffer poor body image too, says teacher*. Retrieved 13th March from: <http://www.bbc.co.uk/news/education-21864312>
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Wiley.
- Biesecker, A. C., & Martz, D. M. (1999). Impact of coaching style on vulnerability for eating disorders: An analogical study. *Eating Disorders: The Journal of Treatment and Prevention*, 7, 235-244.
- Blazina, C., & Shen-Miller, D.S. (2011). *An International Psychology of Men: Theoretical Advances, Case Studies, and Clinical Innovations*. New York: Routledge.
- Boisvert, J. A., & Harrell, W. A. (2012). Ethnicity and spirituality as risk factors for eating disorder symptomatology in men. *International Journal of Men's Health*, 11(1), 36-62.
- Bordo, S. (1999). *The Male Body: A Look at Men in Public and in Private*. New York: Farrar, Straus and Giroux.
- Boyle, M. (1990) *Schizophrenia: A scientific delusion?* London: Routledge.
- Branch, C.H., & Eurman, L.J. (1980). Social attitudes towards patients with anorexia nervosa. *The American Journal of Psychiatry*, 137(5), 631-632.
- Braun, D.L., Sunday, S.R., Huang, A., & Halmi, K.A. (1999). More males seek treatment for eating disorders. *International Journal of Eating Disorders*, 25, 4, 415-424
- Brooks, A., LeCouter, A., & Hepworth, J. (1998). Accounts of Experiences of Bulimia: A Discourse Analytic Study. *International Journal of Eating Disorders*, 24, 193-205.
- Bruch, H. (1973) Perceptual and conceptual disturbances in anorexia

- nervosa. *Psychosomatic Medicine* (1962) 24:287–94.
- Bruner, J. (1990) *Acts of Meaning*. Cambridge, London: Harvard University Press.
- Burns, T., & Crisp, A. H. (1985). Factors affecting prognosis in male anorexics. *Journal of Psychiatric Residence*, 19, 323-328.
- Carlat, D. J., Carmago, C. A., & Herzog, D. B. (1997). Eating disorders in males: A report on 135 patients. *American Journal of Psychiatry*, 154 (8), 1127-1131.
- Carlson, N.L. (1981). Male Client-female therapist. *Journal of counselling and development*, 60, 228-231.
- Carr, A. (2006). *Family Therapy: Concepts Process and Practice* (2nd edn). Chichester: Wiley.
- Chapman, E., & Smith, J. A. (2002). Interpretative Phenomenological Analysis and the new genetics. *Journal of Health Psychology*, 7, 125-130.
- Colton, A., & Pistrang, N. (2004). Adolescents' experiences of inpatient Treatment for Anorexia Nervosa. *European Eating Disorders Review*, 12, 307-316.
- Connell, R.W. (1992). A very straight gay: Masculinity, homosexual experience, and the dynamics of gender. *American Sociological Review*, 57 (6), 735-751.
- Connell, R.W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Re-thinking the concept. *Gender and Society*, 19, 829-859.
- Copperman, J. (2000). *Eating disorders in the United Kingdom: Review of the provision of health care services for men with eating disorders*. Norwich: Eating Disorders Association.
- Corrigan, P. (2004) How stigma interferes with mental health care. *American Psychologist*, 59, 614-625.
- Courtenay, W.H. (2000). Engendering health: A social constructionist

- examination of men's health beliefs and behaviours. *Psychology of men and masculinity*, 1, 4-15.
- Crisp, A.H. (1967). Anorexia Nervosa. *Hospital medicine*, 1, 713-718.
- Crisp, A.H., Burns, T. & Bhat, AV. (1986). Primary anorexia nervosa in the male and female: a comparison of clinical features and prognosis. *British Journal of Medical Psychology*, 59, 123–132
- Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I. & Rowlands, O.J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, 177, 4 – 7.
- D'Abundo, M., & Chally, P. (2004). Struggling with recovery: Participant perspectives on battling an eating disorder. *Qualitative Health Research*, 14, 1094-1110.
- Dallos, R.S., & Draper, R. (2005). *An Introduction to Family Therapy: Systemic theory and practice*, (2nd edn). Maidenhead, UK: Open University Press.
- Dally, P. (1969). *Anorexia Nervosa*. London: Heinemann Medical Books.
- Davis, C. (1999). Perfection as acculturation: a study of the psychological correlates of eating problems in chinese male and female students living in the united states. *International journal of eating disorders*, 25, 65-70.
- DoH (2009). *Delivering same-sex accommodation progress report: the story so far*:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110047
- Dolan, B. (1991) Cross-cultural aspects of anorexia nervosa and bulimia: A review. *International Journal of Eating Disorders*, 10, 67–78.

- Drummond, M. (1999). Life as a male 'anorexic'. *Australian journal of primary health-interchange*, 5, 80-89.
- Drummond, M. (2001). Boy's bodies in the context of sport and physical activity: implications for health. *Journal of physical education New Zealand*, 34 (1), 53-64.
- Drummond, M, (2002). Men, body image and eating disorders. *International journal of men's health*, 1, 89-103
- Drummond, M. (2003). The Meaning of Boys' Bodies in Physical Education. *Journal of Men's Studies*, 11(2). 131-143.
- Drummond, M, (2005). Men's bodies: listening to voices of young gay men, *Men and masculinities*, 7 (3), 270-290.
- Drummond, M. (2011). Men's bodies throughout the lifespan. In C. Blaziner & D.S.Shen-Miller. (Eds.), *An International psychology of men*. (pp.210-236). New York: Routledge.
- DSM working website (n.d.). Revisions to eating disorder diagnoses.
Retrieved on January 6th 2013 from
<http://www.dsm5.org/Pages/Default.aspx>
- Eatough, V., Smith, J. A. & Shaw, R. (2008). Women, Anger, and Aggression : An Interpretative Phenomenological Analysis. *Journal of Interpersonal Violence*, 23, 1767-1799.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38, 215-229.
- Fairburn, C. G. (1992). Interpersonal psychotherapy for bulimia nervosa. In G. L. Klerman & M. W. Weissman (Eds.), *New applications of interpersonal psychotherapy* (pp.353-378). Washington, D. C.: American Psychiatric Press.
- Fairburn, C. G., Cooper, Z. & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: a "transdiagnostic" theory and treatment.

- Behaviour Research and Therapy*, 41, 509-528.
- Fairburn, C. G. & Harrison, P. J. (2003). Eating Disorders. *The Lancet*, 361, 407-416.
- Fennell, M. J. V. (1998). Cognitive therapy in the treatment of low self-esteem. *Advances in Psychiatric Treatment*, 4, 296-304.
- Fernandez-Aranda F., Krug I., Jimenez-Murcia, S., Granero R., et al. (2009). Male eating disorders and therapy: a controlled pilot study with one year follow-up. *Journal of Behaviour Therapy and Experimental Psychiatry*, 40(3), 479-86.
- Freeman, A. (2005) Eating disorders in males: A review. *South African Psychiatry Review*, 8, 58-64.
- French, S. A., Story, M., Remafedi, G., Resnick, M. D. and Blum, R. W. (1996) Sexual orientation and prevalence of body dissatisfaction and eating. *International journal of eating disorders*, 19, 119-26.
- Garfinkel, P. E. & Garner, D. M. (1982). *Anorexia nervosa: a multidimensional perspective*. New York: Bruner-Mazel.
- Garner, D. M., Olmstead, M., Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International journal of eating disorders*, 2, 15-34.
- Gergen, K.J. (1985). The Social Constructionist Movement in Modern Psychology. *American Psychologist* 40 (3), 266-275.
- Goldfield, G. S., Harper, D. W., & Blouin, A. G. (1998). Are bodybuilders at risk for an eating disorder? *Eating Disorders: The Journal of Treatment and Prevention*, 6, 133-157.
- Good, G.E., Dell, D.M., & Mintz, L.B. (1989). Male role and gender role conflict: Relation to help seeking in men. *Journal of counseling psychology*, 36, 295-300.

- Gove, W.R. (1984). Gender differences in mental and physical illness; The effects of fixed roles and nurturant roles. *Social science and medicine*, 19, 77-84.
- Greenberg, S.T. & Schoen, E.G. (2008). Males and eating disorders: Gender-based therapy for eating disorder recovery. *Professional Psychology: Research and Practice*, 39 (4), 464–471.
- Grogan, S., & Richards, H. (2002) 'Body Image: Focus Groups with Boys and Men'. *Men and Masculinities*, 4, 219-232.
- Guba, E.G., Lincoln, E. (1994). Competing paradigms in qualitative research. In NK Denzin and Lincoln Y. S. (eds). *Handbook of qualitative research*. (pp.105-117). London: Sage.
- Hammersley, M. (2000) *Taking sides in social research*. London, Routledge.
- Hepworth, J. (1999). *The Social Construction of Anorexia Nervosa*. London: Sage.
- Herzog, D. B., Bradburn, I. S., & Newman, K. (1990). Sexuality in males with eating disorders. In A. E. Andersen (Ed.), *Males with eating disorders* (pp. 40-53). New York: Brunner/Mazel.
- Hill AJ., & Franklin JA. (1998). Mothers, daughters and dieting: investigating the transmission of weight control. *British Journal of Clinical Psychology*, 37, 3–13
- Jones, W.M., & Morgan, J. (2010). Eating disorders in men: a review of the literature. *Journal of Public Mental Health*, 9 (2), 23 – 31
- Kearney-Cooke, A., & Steichen-Asch, P. (1990). Men, Body Image, and Eating Disorders. In A. Andersen (Ed.), *Males with Eating Disorders* (p. 47). New York: Brunner/Mazel.
- Laing, R.D. (1983). *The Voice of Experience*. Harmondsworth: Pelican.

- Larkin, M. Watts, S. & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102-120.
- Leit, R. A., Pope, H. G., Jr., & Gray, J. J. (2001). Cultural expectations of muscularity in men: The evolution of Playgirl centerfolds. *International Journal of Eating Disorders*, 29, 90–93.
- Leong, F. T. L., & Zachar, P. (1999). Gender and opinions about mental illness as predictors of attitudes toward seeking professional psychological help. *British Journal of Guidance and Counselling*, 27(1), 123-132.
- Madill, A., Jordan, A. & Shirley, C. (2001). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20.
- Mahalik, J. R., Locke, B. D., Ludlow, L. H., Diemer, M. A., Scott, R. P., Gottfried, M., et al. (2003). Development of the Conformity to Masculine norms inventory. *Psychology of men and masculinity*, 4, 3-25.
- Mahalik, J. R., Walker, G., & Levi-Minzi, M. (2007). Masculinity and health behaviour in Australian men. *Psychology of Men & Masculinity*, 3, 240– 249.
- Mangweth-Matzek B, Rupp CI, Hausmann A, Gusmerotti S, Kemmler G, Biebl W. (2010). Eating disorders in men: current features and childhood factors. *Eating Weight Disorders journal*, 15, 15-22.
- McVittie, C., Cavers, D., & Hepworth J. (2005). Femininity, mental weakness, and difference: Male students account for anorexia nervosa in men. *Sex Roles*, 53, 413-418.
- Mead, G. H. (1934). *Mind, Self, and Society*. London: University of Chicago Press.
- Men get eating disorders too (n.d.) Retrieved on 29th November 2013 from

<http://mengetedstoo.co.uk>.

- Meyer C, Leung N, Waller G, Perkins S, Paice N, Mitchell J. (2005). Anger and bulimic psychopathology: gender differences in a nonclinical group. *International Journal of Eating Disorders*, 37(1), 69-71.
- Miller, M. N., & Pumariega, A. J. (2001). Culture and eating disorders: A historical and cross-cultural review. *Psychiatry*, 64(2), 93–110.
- Miller, T., Velleman, R., Rigby, K., Orford, J., Tod, A., Copello, A., & Bennett, G. (1997). The use of vignettes in the analysis of interview data: Relatives of people with drug problems. In N. Hayes (Ed.), *Doing qualitative analysis in psychology* (pp. 201-225). Hove: Psychology Press.
- Morgan, (2010) Eating disorders in men: a review of the literature, *Journal of Public Mental Health*, 9 (2), 23 – 31.
- Morton, R. (1694). *Phthisologica, or, a treatise of consumption*. London: S Smith & B Walford.
- Muise, A., Stein, D., & Arbess, G. (2003) Eating disorders in adolescent boys: a review of the adolescent and adult literature. *Journal of Adolescent Health*, 33 (6), 427–435.
- Mulveen, R. & Hepworth, J. (2006). An interpretative phenomenological analysis of participation in a pro-anorexia internet site and its relationship with disordered eating. *Journal of Health Psychology*, 11 (2), 283-296.
- National Institute for Health and Clinical Excellence (2004). *Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. London: National Institute for Health and Clinical Excellence.
- Newton, M., Boblin, S., Brown, B. & Ciliska, D. (2005). An engagement-distancing flux: bringing a voice to experiences with romantic relationships for women with anorexia nervosa. *European Eating*

Disorders Review, 13, 317-329.

- Palmer, B. (2005). Concepts of Eating Disorders. In, J. Treasure, U. Schmidt & E. van Furth (Eds.), *The Essential Handbook of Eating Disorders*. (pp.1-10). Chichester, Wiley.
- Pikus, C.F., Christopher, L., & Heavey (1996). Client preferences for therapist gender. *Journal of College Student Psychotherapy*, 10, 35-43.
- Polivy, J., & Herman, P. (2002). Causes of Eating Disorders. *Annual Review of Psychology*, 53, 187-213.
- Pollack, W. (1998). *Real Boys: Rescuing Our Sons from the Myths of Boyhood*. New York: Holt Books.
- Pope, H. G., Jr., Olivardia, R., Gruber, A., & Borowiecki, J. (1999). Evolving ideals of male body image. *International Journal of Eating Disorders*, 26, 65-72.
- Real, T. (1997). *I Don't Want To Talk About It: Overcoming the Secret Legacy of Male Depression*. New York: Simon and Schuster.
- Reid, K., Flowers, P. & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, 18, 20-23.
- Ricciardelli, L.A., Mc Cabe, M.P., & Ridge, D. (2006). The construction of the adolescent male boy through sport. *Journal of health psychology*, 11, 577-587.
- Robinson, K., Mountford, V.A., & Sperlinger, D. (2012). Being men with eating disorders: perspectives of male eating disorder service users. *Journal of health psychology*, 18 (2), 176-186.
- Rorty, M. Yager, J. Buckwalter, J.G. Rossotto, E. (1999). Social support, social adjustment, and recovery status in bulimia nervosa. *International journal of eating disorders*, 26(1), 1-12.
- Russell, C.J., & Keel, P.K. (2002). Homosexuality as a specific risk factor for eating disorders in men. *International Journal of Eating Disorders*,

31(3), 300-6.

- Scott, D.W. (1986). Anorexia nervosa in the male: A review of the clinical, epidemiological and biological findings. *International Journal of Eating Disorders*, 5, 799-819
- Sharp, C.W., Clark, S.A. Dunan, J.R., Blackwood, D.H. & Shapiro, C.M. (1994). Clinical presentation of anorexia nervosa in males: 24 new cases. *International Journal of Eating Disorders*, 15 (2), 125-134,
- Siegel J.H., Hardoff. D., Golden, N.H., & Shenker, I.R. (1995). Medical complications in male adolescents with anorexia nervosa. *Journal Adolescent Health* 16, 448–53.
- Siever, M. (1994), Sexual orientation and gender as factors in socioculturally acquired vulnerability to body dissatisfaction and eating disorders. *Journal of Consulting and Clinical Psychology*, 62, 2, 252-260,
- Silverman, J. (1990) Anorexia nervosa in the male: Early historic cases. In A. Andersen (Ed.), *Males with eating disorders* (pp. 3-7). New York: Brunner/Mazel.
- Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, & L. van Langenhove (Eds.), *Rethinking methods in psychology*. (pp. 9-26). London: Sage.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, 261-271.
- Smith, J.A. (2008). *Qualitative Psychology: A practical guide to research methods*. Sage: London.
- Smith, J.A., & Dunsworth, F. (2003). Qualitative Methodology. In K. Connolly & J. Valsiner (Eds.), *The Handbook of Developmental Psychology*. (pp. 603-621). London: Sage.
- Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage

- Smith, J. A., Flowers, P. & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. In: L. Yardley (Ed.) *Material Discourses of Health and Illness* (pp.68-91). London: Routledge.
- Smith, J. A. & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.) *Qualitative Psychology: A practical guide to research methods* (pp.51-80). London: Sage.
- Stiles, W.B. (1993). Quality control in qualitative research. *Clinical psychology review*, 13, 593-618
- Story, M., French, .SA., Neumark-Sztainer, D., Downes, B., Resnick, M.D., & Blum, R.W. (1997). Psychosocial and behavioral correlates of dieting and purging in Native American adolescents. *Pediatrics*, 99, 8.
- Striegel-Moore, R. H., Silberstein, L. R. & Rodin, J. (1993). The Social Self in Bulimia Nervosa: Public Self-Consciousness, Social Anxiety and Perceived Fraudulence. *Journal of Abnormal Psychology*, 102(2), 297-303.
- Striegel-Moore, R.H., Silberstein, L.R., & Rodin, J. (1986). Toward an understanding of risk factors for bulimia. *American Psychologist*, 41, 246–263.
- Vessey, J. T. & Howard, K. I. (1993). Who seeks psychotherapy? *Psychotherapy*, 30(4), 546-553.
- Vincent, M. A., & McCabe, M. P. (2000). Gender differences among adolescents in family, and peer influences on body dissatisfaction, weight loss, and binge eating disorders. *Journal of Youth and Adolescence*, 29, 205-221.
- Vitousek, K. B. (1996). The current status of cognitive–behavioral models of anorexia nervosa and bulimia nervosa. In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 383–418). New York: Guilford Press.

- Vitousek, K. B. & Hollon, S. D. (1990). The Investigation of Schematic Content and Processing in Eating Disorders. *Cognitive Therapy and Research*, 14(2), 191-214.
- Waller, G. (1993). Why do we diagnose different types of eating disorder? Arguments for a change in research and clinical practice. *Eating Disorders Review*, 1, 74-89.
- Waller, G. (2008). A Trans-Transdiagnostic Model of the Eating Disorders: A New Way to Open the Egg? *European Eating Disorders Review*, 16, 165-172.
- Warnock, M. (1987). *Memory*. London: Faber & Faber.
- Wells, A. & Matthews, G. (1996). Modelling cognition in emotional disorder: The S-REFmodel. *Behaviour Research and Therapy*, 34(11/12), 881-888.
- Weltzin, T. E., Weisensel, N., Franczyk, D., Burnett, K., Klitz, C., & Bean, P. (2005) Eating disorders in men: update. *Journal of Men's Health & Gender*, 2 (2), 186-193
- Weltzin, T. E., Weisensel, N., Cornella-Carlson, T., & Bean, P. (2007). Improvements in the severity of eating disorder symptoms and weight changes in a large population of males undergoing treatment for eating disorders. *Best Practices in Mental Health*, 3, 52-65.
- Whittemore R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11(4), 522-537.
- Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Open University Press: Philadelphia.
- Willig, C. (2008). *Introducing qualitative methods in psychology*. Buckingham: Open University Press.
- Woodside, D.B., Garfinkel, P.E., Lin, E., Goering, P., & Kaplan, A.S. (2001). Comparisons of men with full or partial eating disorders, men without eating disorders, and women with eating disorders in the community.

American Journal of Psychiatry, 158, 570–574

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215-228.

Young, J. E., Klosko, J. S. & Weishaar, M. E. (2003). *Schema Therapy: A Practitioner's Guide*. London: Guilford.

Exploring Men's Accounts of Understanding and Seeking Help for Problems with Eating

BACKGROUND

- A recent study by BEAT charity reported that despite the number of male eating disorders significantly increasing, males less readily seek help for problems with eating and when they do seek help their eating problems are less likely to be picked up by professionals.
- Eating disorders can present very differently and can be caused by a multitude of factors. However, there is very little research exploring men's individual accounts of having an eating disorder. Furthermore, whilst it is acknowledged that men, compared to females, do not as readily seek help for eating problems, research has not investigated the reasons behind this difference.

THE STUDY

- This study aims to explore men's individual accounts of understanding and seeking help for eating disorders. In this study, you will be interviewed about your experiences of living with an eating disorder and seeking help for eating problems. You will be asked about factors that may have helped or prevented you from seeking help or accessing care for the eating disorder.
- If you decide to take part in this study, you will be informed of confidentiality and anonymity procedures, and will be asked to sign a consent form to take part.
- The interview will last approximately one hour and will be recorded and transcribed by the researcher.
-

If you are interested in taking part in the study, please contact the principal researcher:

Laura Markham

U1037634@uel.ac.uk

Appendix 2: Information sheet

BACKGROUND

- A recent study by BEAT charity suggested that despite the number of male eating disorder significantly increasing, males less readily seek help for problems with eating (compared to females) and when they do seek help their eating problems are less likely to be picked up by professionals.
- Eating disorders can present very differently and can be caused by a multitude of factors. However, the literature in this field has not yet explored men's individual accounts of having an eating disorder. Furthermore, whilst it is acknowledged that men compared to females do not as readily seek help for eating problems, research has not investigated the reasons behind this difference.

THE STUDY

- This study aims to explore men's individual accounts of understanding and seeking help for eating disorders.
- In this study, you will be interviewed about your experiences of seeking help and accessing care for eating problems. You will be asked about factors that may have helped or prevented you from seeking help or accessing care for the eating disorder.
- If you decide to take part in this study, you will be informed of confidentiality and anonymity procedures, and will be asked to sign a consent form to take part.
- The interview will last approximately one hour and will be recorded and transcribed by the researcher.

Disclaimer

- You are not obliged to take part in this study and should not feel coerced.
- You are free to withdraw at any time.
- Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. [Should you withdraw, the researcher reserves the right to use your anonymised data in the write-up of the study and any further analysis that may be conducted by the researcher.
- Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor

Dr Martyn Baker

Senior Lecturer and Clinical Psychologist
Department of Clinical Psychology
University of East London, Stratford Campus
Water Lane
London E15 4LZ
M.C.Baker@uel.ac.uk

or

Chair of the School of Psychology Research Ethics
Sub-committee: Dr. Mark Finn, School of Psychology,
University of East London, Water Lane, London E15
4LZ.

EXPLORING MEN'S ACCOUNT OF UNDERSTANDING AND SEEKING HELP FOR PROBLEMS WITH EATING

- I have read the information sheet relating the above study and have been given a copy to keep. The nature and purpose of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.
- I understand my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in study will have access to identifying the data. It has been explained to me what will happen once the research study has been completed.
- I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any point without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data in the write up of the study and in any further analysis that maybe conducted by the researcher.

Participant's
name.....

Participant's
signature.....

Researcher's
Name.....

Researchers
Signature.....

Date.....

Appendix 4: Interview schedule

a) How would you describe your problem with eating?

(Prompts: Would you describe yourself as having or having had an eating disorder or a problem with eating? What would you say having an eating problem/ disorder means to you? How is it different from not having an eating problem/disorder?)

b) Where do you think your ideas about eating problems come from?

Prompt: Particular people in your life? Family? Peers? Media?

c) Can you tell me about your experiences of developing a problem with eating?

(Prompts: are there things that contributed to the development of the problem? View of self? images in the media? Family? school? How do you think these factors contributed to the problem?)

d) What is/ was it like having a problem with eating?

(What is your experience of having an eating disorder/problem?)

e) What do you think other people think about eating problems in men? Is this different or the same to how they view eating problems in women?

(Family/parents/siblings, teachers, peers/friends, community? What is this like for you?)

f) What is it like to be male?

g) Can you tell me about your ideas and thoughts around seeking help for the eating problem?

(Did you seek help? If so, how did it feel seeking help? Was it a personal choice to seek help or did others encourage you to seek help? Was this help in the form of peers/family/professionals? How did you find this process and the response of others? Is there anything that would have made this experience easier? Did you face any difficulties seeking help?)

Appendix 5: Revised Interview schedule

N.B. **Bold font** is used to indicate questions considered to be particularly helpful in facilitating interview process and exploring answers further

Red font is used for questions added to the schedule

- a) How would you describe your problem with eating?
(Prompts: *Would you describe yourself as having or having had an eating disorder or a problem with eating? What would you say having an eating problem/ disorder means to you? **How is it different from not having an eating problem/disorder? What was it like for you?***)
- b) Where do you think your ideas about eating problems come from?
Prompt: Particular people in your life? Family? Peers? Media?
- c) Can you tell me about your experiences of developing a problem with eating?
(Prompts: ***are there things that contributed to the development of the problem?*** *View of self? images in the media? Family? school? How do you think these factors contributed to the problem?*)
- d) What is/ was it like having a problem with eating?
(*What is your experience of having an eating disorder/problem?*)
- e) What do you think other people think about eating problems in men? Is this different or the same to how they view eating problems in women?
(*Family/parents/siblings, teachers, peers/friends, community? What is this like for you?*)
- f) What is it like to be male? **Can you give me an example of this?**
- g) Can you tell me about your ideas and thoughts around seeking help for the eating problem?
(*Did you seek help? If so, **how did it feel seeking help?** Was it a personal choice to seek help or did others encourage you to seek help? Was this help in the form of peers/family/professionals? How did you find this process and the response of others? Is there anything that would have made this experience easier? Did you face any difficulties seeking help?*)

Appendix 6: Extract from research journal

Observations were recorded in the research journal. The observations included reactions in the interview and anything considered useful for the analysis process, including sociocultural factors. Beginning at the stage of transcription, significant 'objects of concern' and any 'experiential claims' that the participant mentioned were recorded (Larkin, watts & Clifton, 2006). Observations during this stage also included references to potent parts in the transcript, assumptions or biases made by the researcher. In summary, anything that was felt by the researcher to be of significant and would be important to be revised at a later stage was documented.

Below is a compilation of the main reflections noted in relation to Gerry. The reflections were written at various time-points: directly following the interview ((1) and (2)), during the stage of transcribing (3), and directly following transcription ((4) and (5)):

(1) Context and content of interview:

- ❖ Appearance –well below average in body weight, wonder whether he still suffered from an ED. How would he feel about sharing his story if his story if still on going? My role?
- ❖ Very enthusiastic and keen to make me feel welcome.
- ❖ Interview in a location he had previously worked in
- ❖ Specifically sought out people that he used to work with to say hello. Confidence- less worried about telling his story and he seemed excited and engaged to be there/ I felt pleased and at ease

(2) Process of interview

- ❖ Participant taking more of an active role
- ❖ Often straying from the loose focus of the eating disorder- wanted to tell me about many areas of his life outside of the eating disorder.
- ❖ Initially concerned by him veering from topics but wondered about importance of the sharing less problem-saturated story. ED does not define him
- ❖ Isolation in story but engaged well and spoke of lots of friends since ED

(3) From transcribing:

- ❖ Enthusiastic nature of his voice
- ❖ V quickly familiar with interviewer.
- ❖ Noticed my attempts, at times, of re-directing conversations to keep focused on the aims of the interview.
- ❖ Long period of time talking about marathon.
- ❖ Little pauses- why are less pauses in this interview?

(4) On reading the transcript:

- ❖ Dominant themes/ discussion- stigma from others (v. different from experience of meeting participant.. seemed v at ease with members of the community he saw in the coffee shop)
- ❖ Feelings of now being accepted – marathon
- ❖ Achieving something/ now he mattered and stood out in the community/ isolation (others didn't want to know)/ that he should not be defined by eating disorder

(5) Possible assumptions I might be making:

- ❖ Difficulties in his childhood related to the development of eating disorders.
- ❖ He challenged assumptions about ed (was he particularly keen to challenge my assumptions due to my professional status and his negative experience of status)
- ❖ Aware of his identity- was this how he described the process of change or had I imposed prior psychological knowledge? Assumption that he felt confident in telling his story (was this anxiety?)

Appendix 7: An example of the transcription scheme used (adapted from Banister et al., 1994)

(.)	Pause
...	Denotes words that have been cut out to ensure that excerpts are concise and clear; care has been taken not to alter participants' intended meaning in any way.
[]	used to make quoted text more understandable without changing the meaning
[inaudible]	Inaudible section of transcript
<u>emphasis</u>	Word(s) spoken with more emphasis than others
[laughs]	Laughter during interview
/	Interruption or overlapping talk
<>	Brief interjection by other speaker
change↑ing	Step up in pitch to the prominent syllable 'ing' (↓ would denote a step down in pitch)

Initial coding

Red= conceptual
comments/questions

Green= linguistical

Blue =descriptive
comments

Appendix 8: Extract from Thomas' annotated transcript

1
2 **Laura: I am using IPA, so really the idea behind the interview is for**
3 **it to be your experiences, rather than me asking you a number of**
4 **questions. In your eyes, how would you describe your eating**
5 **problem?**

6 X: ooh, well think it's different now. It's
7 different in two ways now than it was in the
8 past. So in the past I think it was a lot more
9 consuming. And I felt as though **I was living in**
10 **it.** I felt as if was the **sum total** of me **actually**
11 for a long, an awful long time. Err, and I felt as
12 if at the time **I don't think that I realised that**
13 **felt there was a problem.** And then after I was
14 diagnosed, my first diagnosis, I was then
15 **massively** in **denial.** And it wasn't a denial I was
16 aware of, until hindsight. So I am able to
17 recognise that that's what it was now, that I
18 was **massively** resisting any form of help or
19 treatment. Almost kind of maintaining my
20 disorder. Ermm, and then, and now its
21 changed. At present my eating problems are
22 different, first of all I was then re-diagnosed at
23 the end of one treatment cycle. So I moved
24 from being diagnosed with Bulimia Nervosa. I
25 had **massive** issues with purging and **I was**
26 **really damaging myself** with my purging
27 behaviours and then..So that was the first
28 element of the disorder that went, through
29 treatment. Then I was re-diagnosed, I had to
30 go back every 6 months, to talk to my doctor
31 and then I was re-diagnosed with Binge Eating
32 disorder. So that's what is being worked on
33 now. But I feel as if something's, it didn't
34 happen at the point that the re-diagnosis
35 happened. **Something shifted** around a similar
36 time and I don't feel as consumed by it now. So
37 I feel as if there are **days when I have clarity**
38 and I don't feel as if all I do is think about food
39 or not think about food. Because I spend a lot
40 of time thinking about not having food.
41 Errm,(pause), but, that kind of means that I
42 feel as if I have **good days and bad days.** Which
43 is you know, a **typical thing to say.** But I still

All encompassing – cage like

Lack of awareness

Paradox- Being totally encompassed yet unaware. Changing ideas about agency

Extent

Changing over time

Agency?

Being worked on by whom? Who is important in the process of recovery?

Process of realisation

Emphasis

'typical' thing to say for whom?

Identity. Does the 'eating disorder' define him?

Disbelief/lack of acknowledgment of problem

Resistant to help

Paradox: Benefits of disorder/punishing behaviours

Punitive behaviours – why did he deserve to be punished? function-psychological/physiological. Self- concept?

Unique ideas of recovery

All- encompassing

Comparison to life of someone without ED	44	feel as if the good days wouldn't be the good	
	45	days someone would have if they didn't have	
	46	an eating disorder. I suppose is what I would	
	47	say. And another thing, I didn't realise, in my,	
	48	all through my twenties.... so after I left home I	
Highlights the extent felt	49	went to University and I was just complete, I	
	50	was really depressed and very erratic, really	
	51	punitive with myself. I didn't kind of realise	Function/benefit of 'eating disorder'
	52	that at the time, I just thought that was how	
'normal' to punish? Again Comparison to 'normality'? consideration of social standards	53	everybody was with themselves. And my way	
	54	of punishing myself was through food and	
	55	through the purging behaviours that I had. But	Long time period between symptoms commencing and finishing
	56	I didn't really; I wasn't diagnosed until I was in	
	57	my twenties, in my early twenties. But I	
	58	started having massive issues with eating when	
	59	I was a teenager. So I had problems with food	
longevity of problem	60	from being kind of fourteen roughly. But one	
	61	side of it, the first time I started earning	Agency
	62	money, so when I had my own money to buy	Secrecy—isolation
	63	things, I bought food then refused to eat for	
	64	ages because I had eaten all this food. So then	
	65	I have to kind of hide food at home and not, to	
	66	make sure that I didn't eat for days. Ermm, but	
	67	yeah, my parents kind of, I was about to	
'forced' – similarity to being punished	68	forced, but it was forced in a parental way not	Perspective of parents
	69	in a kind of Victorian mum and dad way. They	
role of family	70	have a strong work ethic and they were like,	
	71	right we'll still give you your pocket money but	
	72	now you're wanting more money you have to	Growing up/ taking charge of own decisions/ transition-facing a scary and intimidating world
	73	go out and earn that money and then we'll give	
	74	you the equivalent amount if you are earning	
	75	it. So I got a paper round. And I was terrified.	
	76	(Pause) cos I was wandering around strange	
representation of the world	77	streets (laughs), with big dogs and erm and I	
	78	was a sensitive little boy I suppose. I wasn't	Comparison based on body/ sporting prowess
	79	some sort of big brash footballer player like my	
	80	dad. So actually, I just lived in more fear of	
sense of being 'little' compared to 'big' dogs and a bigger worlds	81	going out on my paper round. I actually think	
	82	now is, really I've been a teacher, I've been	Perspective as adult
	83	primary school teacher since and I think that is	
	84	a really tough thing to put a kid through,	Hindsight/ retrospective perspective
	85	actually. I think it is different if the kid had	
traumatic experience in childhood	86	wanted to do it, like up for the challenge. But	
	87	it really scared me and erm, it and I really can't	

Appendix 9- Emergent themes from Henry's account

Superordinate	Subthemes	Line number	Quote	Initial coding notes and reflections
All encompassing	Ongoing/lack of break	L38	It is something you have to be on top of the whole time	<i>Sense of power and over-bearing nature of 'eating disorder'.</i>
	Continuity	L177	So every single minute of <u>every single day</u> , you are aware of food, you are aware of how much food is in front of you, what's around you, you are <u>constantly</u> thinking about food, it becomes that trigger of, this is me, going to lose control	<i>'Eating disorder' externalized/separate to him? Locus of control?</i>
	Social world-importance of food			<i>Use of 'you' as opposed to first person. List of areas that it controls emphasises the effect of the 'eating disorder' on all areas of his life.</i>
Paradox-all encompassing yet relating this experience to 'eating disorder'	Lack of awareness	L301	I went for quite a long time without actually realising I had an eating disorder	<i>Denial? Lack of awareness? Disbelief? Relationship to social discourses</i>
Perception of 'eating disorder'	Physical aspect of 'eating disorder'	L328	I think it was a big shock from health perspective as well, that kind of, made me realise that the only way to address this was to start looking at my life	<i>Physical consequences more noticeable than psychological/behavioural changes.</i> <i>Representation of eating problem as physical problem? Influenced by social discourses that emotional issues should not be a problem for men?</i> <i>Disease model representation of AN.</i>
Punishment	Lack of control	L142	When you read about people who have had an out of body experience its very similar to that.. You are aware of while it is going on but physically you can't actually stop. So you kind of struggle between mentally what you telling yourself and physically what you are doing.	<i>Separation between body and mind? How does he view the connection between body and mind? Use of the 'struggle' conveys ongoing battle.</i>
		L153	It's as if something does literally take over your physical side of	<i>Consciously trying to 'get rid of it'</i> <i>Struggle- ongoing battle</i>

			your body and your mental side is sort of trying to get rid of it	<i>The power of the ED. Lack of control. 'rid of it'= it is recognised as something that needs to be destroyed</i>
Control/agency	Agency	L44	You lose all control, you are aware of what's going on around you and what is going on around you but you are not mentally controlling what your body is doing	<i>The punishment not expressed as being consciously inflicted by self- it is out of his control. Is there a function to the punishment. Feeling that this is an external force creating the punishment.</i>
	Lack of power	L164	I suppose the loss of control is what is the scariest thing about it. Cos you are not in control of what you are doing. I suppose in the same way as people who go out and get smashed drunk and you know you can't physically control what they're doing.	<i>Feeling of fear-perpetuated by having no opportunities to talk about the problem and isolation. Comparison to being drunk but being drunk is a choice?</i>
Growing up	Traumatic childhood experience	L63	It kind of came about from, er, my parents split from when I was about 3 or 4.. I was living with my mum and husband who basically brought me up until the age of 11 and then they decided to split as well...It <u>got to the point</u> where I realised there were abandonment issues.	<i>Instability in upbringing. From adult perspective-realises abandonment issues/ how did he make sense of the experience at the time. At what point? After the experience? After therapy?</i>
Growing up	Family structure and mealtimes	L84	We never had any formal meal times.. we were kind of relied on to sort our own.. the ball was in our court to say well you are responsible for your own eating.. there was not sort of formality there	<i>Role of others in development of 'eating disorder', understanding of food Starting to make own decision growing up—he had control over what he ate and in structuring meal times. Was this at a point of transition too?</i>
Interpersonal	Deterioration in relationships	L281	At times it was very isolating, cos you are dealing with a lot of mental problems and issues that you cant really explain to anyone else What I was doing a lot of time.. I was putting my opinion in people's mouth.	<i>Does he feel that he does not have the ability to express difficulties or is there no around who will listen and take him seriously? Whose choice is the isolation? Is it enforced on him? Not being able to explain perpetuated by own disbelief.</i>
Treatment /experience of	Experience of CBT	L411	From the CBT point of view, it caused me more problems than it	<i>Sense that treatment exposed wounds but did not heal them.</i>

help	Relationship component		solved because of the short period of time that I did have me looking into relationships to do with my relationships and then that being left open	<i>Content and time-limited piece of therapy unhelpful.</i>
	Lack of information	L252	No extra information that was given to me, to kind of well, this is how we deal with it, this is how you need to start approaching it... I was given nothing, I was just told what it was and then I did an internet search to find whatever it means	<i>Negative experience of seeking help- wanted straightforward practical information about how to best move forward. Importance of learning about eating problem.</i>
		L261	They did refer me to erm for some, for some cbt.. Virtually no help at all er, such a short period of time	<i>Restraints of service- content and time-period not helpful</i>
	Need for strategy in moving forward	L268	It didn't give me a bigger picture of, any kind of strategy, of working towards myself to deal with it erm.	<i>Indicates what would have been valued in psychological approach. Wanted help to help himself/. Importance of having agency in help-seeking process</i>
	Importance of validation	L308	it came to a point of treating myself ...Every time it seemed you were taking a step forward you would start to doubt that was the right way you should be going	<i>Self-doubt feeding into recovery process.</i>
	Not feeling like the only one	L363	It still helps to realise that other people have that too.	<i>Importance of meeting others that had same difficulties. Relieving sense of self-doubt around whether the problem existed?</i>
	Different outlet		What I've actually found through creative writing that I am doing and writing the blog, a coping mechanism for me, being able to deal with some of the more negative emotions.'	
Relationships	Deterioration	L272	It did start to affect my relationship with my wife as well..	<i>All- encompassing</i>

			There are certain things I have to approach in a certain way	<i>Conscious to approach things in a particular way. Mindful of the impact of ED. All encompassing nature.</i>
	Relationship with self/understanding of self	L53	There were the feelings of guilt and shame and everything that came along after that	<i>Shame based- perpetuated by discourses around ED as female problem? Contending with double stigma</i>
	Disbelief in others The effect of disbelief in others Importance of validation in help seeking	L19 L187 207 221 343 372 337	<p>Well I think even now some family still don't believe that</p> <p>I still don't think that people quite believe that (pause) erm, binge eating disorder is actually something that can happen, I mean, not necessarily to men but also with women as well</p> <p>In trying to explain it to other people and other people believing it, err, it was very difficult.</p> <p>The look of disbelief on people. The hardest thing to take I think as well.</p> <p>But fortunately.. the consultant that takes the group is actually a man as well, who had gone through the whole process of losing weight, he was really good in chatting to me.</p> <p>I can talk to those people without any kind of judgement</p> <p>That was very intimidating in itself because I'm a guy walking into a class that is pretty much filled with women.. am I going to be laughed at, am I going to be seen as this oddity.</p>	<p><i>Disbelief perpetuating shame-based beliefs?</i></p> <p><i>Is binge eating disorder less accepted than other ED? Due to physical differences?</i></p> <p><i>Contending with double stigma</i></p> <p><i>Feeling that he had to explain the difficulty? Did he feel he had the language to explain. Related to lack of information.=/opportunities</i></p> <p><i>Importance of speaking to people that have been through it to/ validation that the problem does exist/ contrasting experience who respond with disbelief</i></p> <p><i>Importance of moving self from situation of stigma in reaching recovery</i></p> <p><i>Concerns about approaching the group and seeking help</i></p>
	Importance of others in help-seeking	L30	It was my wife that put me to it, a questionnaire about eating things, because she had noticed, small little things that I was doing that I wasn't aware of	<i>Why was he not aware? Has earlier spoke about the power of the body in making him doing things that his mind was fighting against. Did he not want to be aware? Earlier discussion of need for information suggests that he</i>

				<i>needed more(psychoeducation) information to recognise , acknowledge problem</i>
--	--	--	--	--

Media	Increased aesthetic focus for men	L190	I think the whole media image that's portrayed, you know the stick thin figure..guys are getting the same kind of treatment with the six pack ripped figure, sort of being what you should aspire to.	<i>Role of the media in perpetuating the problem. Change in social pressure for men. Increased aesthetic onus. Feeling that he 'should' aspire to these images. Who is making him feel that he should aspire to such image? Who is this pressure coming from? Is it solely the media?</i>
	Lack of male 'ed' awareness	L475	It's not talked about in the magazines ...I just think [if it was talked about] people would be aware of what it is and not feel as if it's something they've made up in their minds	<i>Paradox of increased pressure for men to conform to a certain image and yet restricted opportunities to discuss body image issues. Disbelief from others internalized by him?</i>

Appendix 10: List of potential superordinate and emergent subthemes⁵⁰

Superordinate theme	Emergent subthemes ⁵¹
All Encompassing	Paradox of being completely encompassed but unaware of diagnosis
	Sum total of them/ part of their identity
	All encompassing even in recovery
	Enduring nature likened to be being punished and relentless
Continuity	No way out
	Don't want to see a way out
	Lack of agency
Unawareness	Long period of time without realising their was a problem
	Unawareness of others until physical changes in participant
	Not recognising symptoms
	Not wanting to recognise symptoms- recognising symptom meant letting go of 'eating disorder'
Being a man	Not feeling able to express difficulties
	Increasing pressure from media to conform to muscular image
Externalisaion	Out of body experience
	Being disconnected from body
	External force and power
Punishment	Self inflicted through purging
	Punishment after loss- could not justify living life normally
	Highs from self-inflicted punishment

⁵⁰ This is an amalgamation of themes derived from each participant. Please note that at this stage of the analysis themes were subject to change (e.g. 'emergent' themes becoming 'superordinate' themes and 'superordinate' themes collapsed into subthemes), based upon continual analysis of the data through the 'lenses' of different themes (see Smith et al, 2009).

⁵¹ Please refer to Appendix X or an example of initial coding notes. Due to the size of the original document, the column of initial notes has been removed from this version.

	Powerful external force punishing
	Punishing as being functional way to process emotions
	Loss of control
	Not being able to stop punishing self- paradox of punishing self but not wanting to
Agency	No control over punishing behaviours- external force
	Disconnection from body/outside world
	Fear of losing control
	Others not understanding lack of agency
Late diagnosis	Not being diagnosed till some time after eating disorder beginning
	Lack of available help/ wrong type of help
Comparison to others from young age	Physical comparison to other boys- feeling overweight
	Comparison in sporting activities – sport= status
	Not feeling ‘good enough at anything’ / wanting to be different
	Comparison to others prompted by parents
	Others comparing participant to image of masculinity
	Being considered to be too effeminate leading to internal and external question of gender/sexuality
Being a boy	‘Never a boys boy’
	Pressure to conform to being boys boy
	Trying to conform but this process feeling unnatural
	Emphasis on what the male body could do and what the male body could be
	Increased understand of pressures endured as a boy now as an adult
	Isolation- not fitting in
	Being bullied for not fitting in
	Re-moulding self to fit in
	Not being a boy’s boy associated with being effeminate and not fitting in— questions from self and others about sexuality?

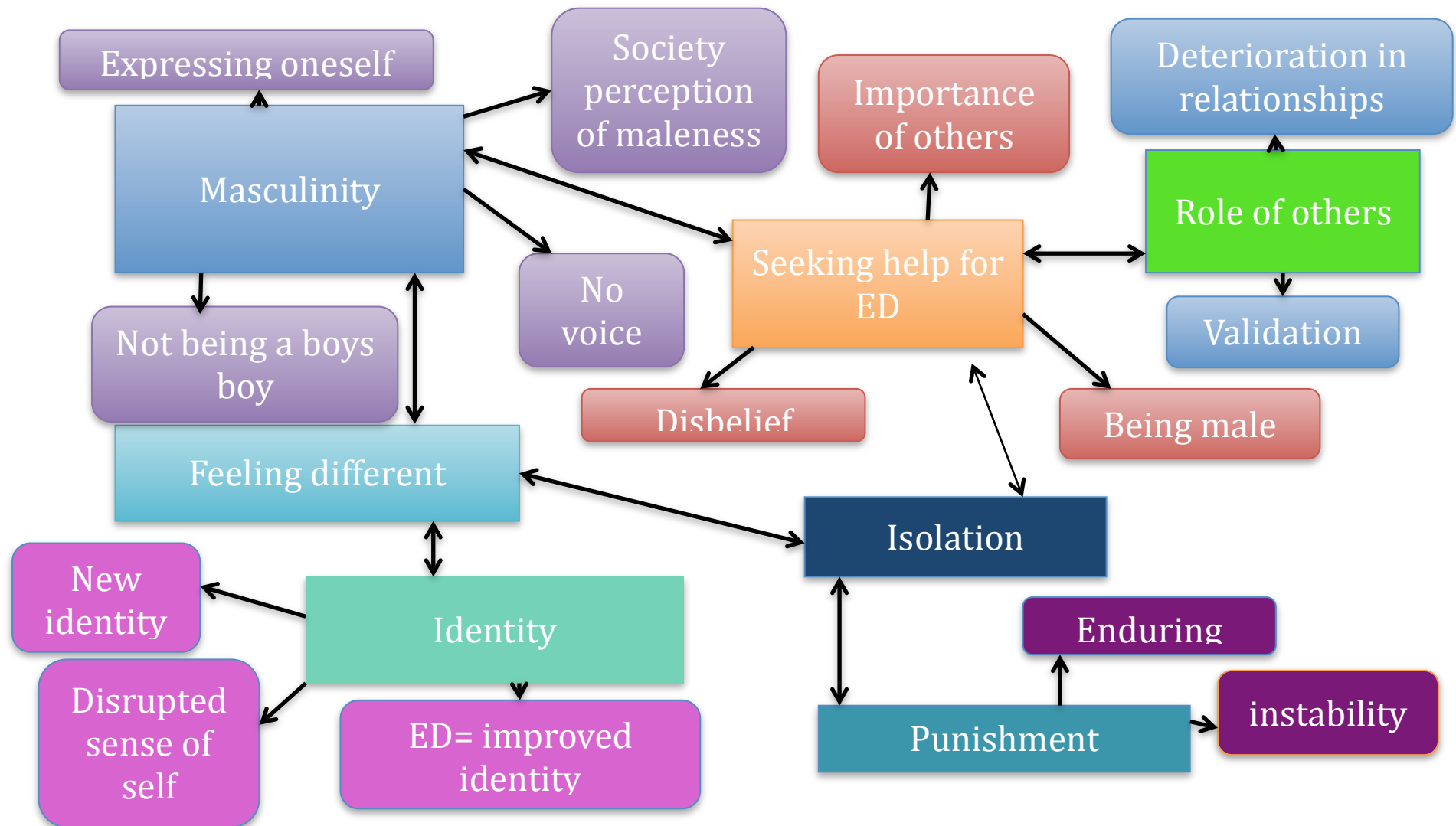
	Isolation and bullying as a result of being considered effeminate
Eating disorder as new identity	Being an expert
	Being thinner = being better at sport
	As an excuse to not being expected to achieve or live prescribed life
	Escapism
	Short term highs of engaging in eating disordered behaviours 'successfully'
Deterioration in social relationships	Isolation/loneliness/ avoiding social contact
	Moving away/isolation allowing eating disorder to progress further
	In hindsight- distress at the way relationships were perceived neglected during period of having eating disorder
	Feeling avoided- links made to discrimination and stigma associated with being a man with an eating disorder
	Feeling that others made assumptions that others made about men with eating disorder
	Being in a box/alone/no escape
	Others affecting mood positively and negatively
	Disbelief of others Novelty of 'eating disorder' in men
Disbelief	Men cant get 'eating disorders '
	Self- disbelief -There is no single cause of 'eating disorder'
	doubt perpetuated by others reactions and lack of media interest in men with 'eating disorders'
	Media- no role models with whom to identify- 'can men get 'eating disorders?'
Others in recovery	Importance of validation
	Others recognising symptoms / others concern
	Seeking help motivated by relieving others of the distress associated with participant's 'eating disorder'
	Not wanting to let others down

	Stigmatisation in professionals hindering process to recovery
Conflicts in road to recovery	'Eating disorder' seen as way to stand out and be different yet also associated with not fitting in (in a negative way) Worrying about what would be left if 'eating disorder' let go
	Negative reaction from professionals
Eating disorder as female disorder	Role of media in presenting it as a woman's problem
	Perception of others- disbelief in others
	Why would men talk about body concerns? Why would men be worried about bodily concerns? Feeling unable to talk about concerns with other males
	Society's ideas around men and confiding to problems, especially problems considered to be a woman's problem
Awareness of body	Perpetuated by commercial greed
	Awareness in boyhood/ relationship of appearance of boy to what a boy was perceived to be able to do and achieve
	Paradox of needing to look a certain way but not being able to express concerns about body as this was not considered masculine appropriate behaviours
Seeking help	Negative experiences with professionals
	Positive experience of being only male in all female environment
	Simplicity of approach- someone to listen and validate experience
	Implications of seeking help meaning that 'eating disorder' maybe cured Concerns around this process
	Isolation
	Self doubt around having an 'eating disorder'- connected to 'eating disorder' being seen as a woman's problem
	People can't handle the 'messy' nature of the disorder
	All female environments
Self esteem	Affected by experience of body/comparison to others
	Feeling not good enough/ needing to do more to reach the same level as

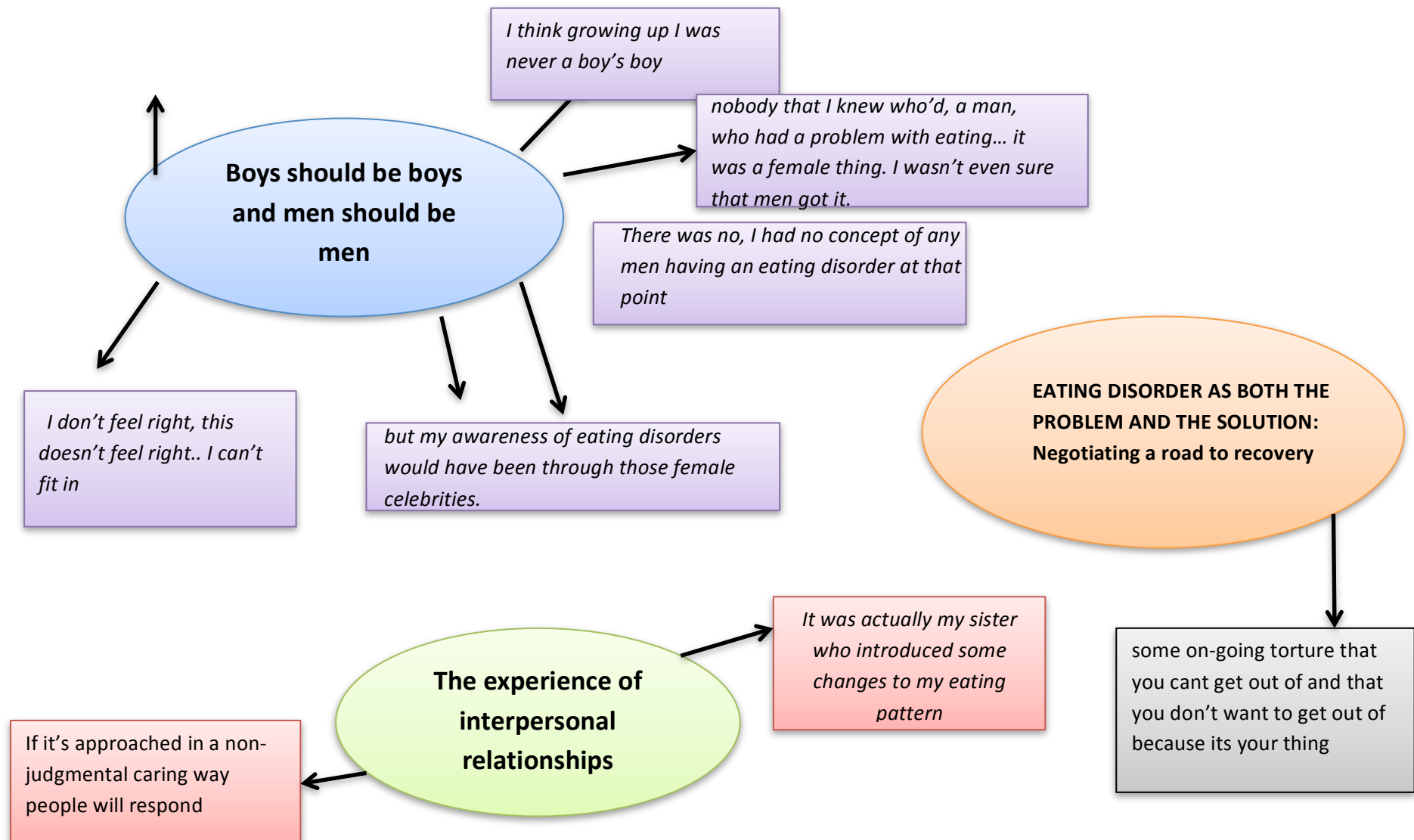
	others
	Not feeling accepted/ being different/ wanting to be different in a positive way
High achiever	High-achievement in areas unassociated with masculinity
Binary assumptions of men and women in others and self	Men should not get eating disorder/ men should be tough/ men should not talk/ men should not be feminine
Others awareness of eating disorder	People avoiding the topic
	Others becoming concerned
Experience of treatment	Negative experience of short-term CBT
	Fears of engaging with treatment
	Dissatisfaction/ Lack of information
	No life –lines
	Positive experience of being only male in female inpatient service
	assumptions of negative childhood made by professionals
	Importance of accessing information on the internet
Helping self	Not knowing how to help self, where does one access information?
	Not wanting to help self for fear of letting the eating disorder go
Monotony of eating disorder vs excitement and highs from succeeding in eating disorder	Repetitive nature of the disorder and the need to strive for highs All consuming – affecting all areas of life. 24 hours Acting as a social deterrent
Diagnosis/ perception of mental health	Other perceptions that AN followed a disease model of treatment
	Physical threshold for ED
intangible nature of ‘eating disorder’	Until the effects of disorder became visible, others did not understand or believe the disorder
Attraction	Wanting to be attractive to others
	Not being able to express fear around being attractive
	Lack of opportunity to discuss aesthetic concerns with other men
Media	Effect of media on self-image, Increasingly toned and muscular images

	fuelled by commercial greed
	Lack of media attention to males with eating disorders
Dysfunctional eating patterns in the family	Parents on diets
	Lack of normal mealtimes
Society and food	Role in social engagements
	Abundance of food and focus on dieting and calorie control
Feeling invisible as a man with an eating disorder	Feeling like the only male
	Not being able to speak to others/ others not wanting to speak to them
Gender issues affecting treatment	All treatment information geared to females
	Preferring to talk to men/ females
	Not feeling able to express self
Uniqueness of experience	There shouldn't be a one size fits all treatment plan
	Men will want different things from treatment- self-help groups/female help/ just simply validation and an opportunity to talk to peers
	There is no single cause of 'eating disorder'

Appendix 11: Mind map of emerging themes across participants



Appendix 12: Example mind map (within-participants themes for Frederick)



Appendix 13- Ethics approval letter

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London
www.uel.ac.uk

School of Psychology Professional Doctorate Programmes

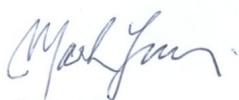
To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

Stratford Campus, Water Lane, Stratford, London E15 4LZ
tel: +44 (0)20 8223 4966 fax: +44 (0)20 8223 4937
e-mail: mno.davies@uel.ac.uk web: www.uel.ac.uk/psychology



The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853

