

ETD Archive

2014

Men Making Meaning of Eating Disorders: A Qualitative Study

Robin Leichtman
Cleveland State University

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/etdarchive>

 Part of the [Education Commons](#)

[How does access to this work benefit you? Let us know!](#)

Recommended Citation

Leichtman, Robin, "Men Making Meaning of Eating Disorders: A Qualitative Study" (2014). *ETD Archive*. 177.

<https://engagedscholarship.csuohio.edu/etdarchive/177>

This Dissertation is brought to you for free and open access by EngagedScholarship@CSU. It has been accepted for inclusion in ETD Archive by an authorized administrator of EngagedScholarship@CSU. For more information, please contact library.es@csuohio.edu.

MEN MAKING MEANING OF EATING DISORDERS:

A QUALITATIVE STUDY

ROBIN LEICHTMAN

Bachelor of Arts in Communication

Cleveland State University

December, 1995

Master of Education in Elementary Education

John Carroll University

May, 1999

Master of Education in Community Agency Counseling

Cleveland State University

May, 2009

submitted in partial fulfillment of requirement for the degree

DOCTOR OF PHILOSOPHY IN URBAN EDUCATION

at the

CLEVELAND STATE UNIVERSITY

JUNE, 2014

©Copyright by Robin Leichtman 2014

We hereby approve this dissertation of

Robin Leichtman

Candidate for the Doctor of Philosophy in Urban Education degree

This Dissertation has been approved for the

Office of Doctoral Studies,

College of Education and Human Services

and

CLEVELAND STATE UNIVERSITY

College of Graduate Studies by:

Dr. Sarah Toman: Committee Chairperson
Counseling, Administration, Supervision, and Adult Learning

Dr. Catherine Hansman: Methodologist
Counseling, Administration, Supervision, and Adult Learning

Dr. Kathryn MacCluskie; Committee Member
Counseling, Administration, Supervision, and Adult Learning

Dr. Brian Harper; Committee Member
Counseling, Administration, Supervision, and Adult Learning

Dr. David Prybock; Committee Member
Private Practitioner

June 23, 2014

Student's Date of Defense

ACKNOWLEDGEMENTS

This dissertation represents my commitment into the study of men with an eating disorder. Thanks to six brave men, I am closer to understanding the male experience of having an eating disorder from etiology to recovery/maintenance. In addition to Scott, Jay, Casey, Michael, Chris, and Edward, I want to acknowledge the support and encouragement of many people.

I am thankful for this opportunity to express my sincere gratitude to the many individuals that have mentored me through the writing of my dissertation. To my Chair and Gestalt confidante, Dr. Sarah Toman, I cannot find the words to express how indebted I am to you for the many kindnesses you have shown me along the way. Thank you for supporting me through all my growing pains. To my methodologist, Dr. Catherine Hansman, thank you for all of your continuous support and advice in helping me go “deeper” in my analysis. Your consistent “clarify” boosted my confidence and emboldened me to take on challenges I did not believe I could accomplish. I want to sincerely thank my committee members, Dr. Kathryn MacCluskie, Dr. Brian Harper, and Dr. David Prybock, for their dedicated time and energy on my behalf. I felt the moral support each of you gave throughout this process. In addition to the individuals on my committee, I also want to express my sincere gratitude to additional instructors who have mentored me along the way including Dr. Ann Bauer, Dr. Dilani Perera-Diltz, Dr. Elizabeth Welfel, Dr. Elliott Ingersoll, Dr. Carl Rak, Renee Kolecki, Rick Hancock and the entire Gestalt Institute of Cleveland community.

I feel blessed to have had the consistent support of my many incredible friends, peers, and colleagues of which there are too many to list here, but your names are forever inscribed on my heart.

Last, but not least, my entire family with a special tribute to my dad (of loving memory), who is my guiding spirit, my mom, who cheers and applauds my every step unconditionally, and my Bud, my most loyal companion who reminds me daily “to be” and live in the moment.

MEN MAKING MEANING OF EATING DISORDERS:

A QUALITATIVE STUDY

ROBIN LEICHTMAN

ABSTRACT

There is a stark contrast between the research and published accounts reflecting women's experiences in coping with an eating disorder in comparison to men's narratives. Because of this, many medical and mental health providers do not consider an eating disorder as a possible diagnosis when men present with symptoms associated with an eating disorder. This notion was confirmed by Menstuff® (2012), who reported men are often not diagnosed and/or are embarrassed by being diagnosed with an eating disorder because eating disorders have become more associated with a problem women or gay men experience. Assumptions that eating disorders are a female or gay disease need to be disputed to relay the reality that eating disorders are nondiscriminatory. It is necessary to create a safe path for men to seek treatment. According to Andersen, Cohn, and Holbrook (2000), men account for one in six eating disorder cases.

The intention of this dissertation is to give voice and provide insight into the males' experiences. The main research question of this dissertation is, "how do men make meaning, from etiology to recovery, of their experience in having an eating disorder?" The six men who participated in this dissertation research helped answer that question by telling their stories. While I cannot generalize these findings into the general male population, the stories of these six participants contributes to the literature in understanding how men experience acquiring an eating disorder, the treatment process, and the recovery/maintenance stage.

This dissertation study further explored understanding the interdependence between self-concept and eating disorders. A treatment protocol focused on treating symptoms can often threaten the psychotherapeutic relationship and prevent the patient from becoming wholly healthy. Rogers (1951) theorized that the more aware and accepting an individual is about all parts of self, the clearer, integrated, and actualized a person's self-perception will become. A holistic approach recognizes the multidimensional overlapping of fluid energy between body, mind, and spirit and restores vitality. According to Gestalt theory, "change does not take place by trying coercion, or persuasion, or by insight, interpretation, or any other such means. Rather, change can occur when the [client] abandons, at least for the moment, what he would like to become and attempts to be what he is" (Beisser, 1970, p. 77). In other words, the potential for change occurs when individuals find compassion and acceptance for self. My findings suggest that treatment interventions, like exploring the client's context and contact style, could assist individuals in developing a healthier self-concept whereby eating disorder symptoms would dissipate and organic self-regulating processes would be restored by way of a dialogic relationship that goes beyond correcting behavior.

TABLE OF CONTENTS

ABSTRACT	vi
LIST OF TABLES	xv
LIST OF FIGURES	xvi
CHAPTERS:	
I. INTRODUCTION	1
Conceptual Underpinnings for the Study.....	8
Theoretical Framework.....	13
The Gestalt approach.....	15
Cycle of experience.....	15
Gestalt contact styles.....	17
Desensitization.	18
Deflection	18
Introjection	18
Projection.....	19
Retroflexion.....	19
Egotism or Self-Monitoring.	19
Confluence.....	20
Gestalt approach summary.....	20
Review of Therapeutic Approaches.....	22
Treatment Options	26
Definition of Key Terms.....	26
Disordered Eating.....	28
Anorexia Nervosa (AN)	28

Bulimia Nervosa (BN).....	29
Eating Disorder Not Otherwise Specified (EDNOS).....	30
Binge Eating Disorder (BED)	31
Night Eating Syndrome	31
Reverse Anorexia (also termed the Adonis complex).....	31
Problem Statement	31
Purpose of the Study	32
Research Questions.....	34
Limitations	34
Summary	35
II. LITERATURE REVIEW	36
Introduction.....	36
Eating Disorders and Gender Issues	37
Eating Disorder Risk Factors	41
Clinical Features	43
Biological Factors	47
Personal Narratives	48
Michael Krasnow	48
Ralph Wilps, Jr.....	49
Ron Saxon.....	49
Qualitative Studies	50
Treatment and Recovery	52
Theoretical approaches to treatment.....	58
Gestalt approach.....	59

Gestalt testimonial	63
Gestalt approach summary	63
Summary	65
III. RESEARCH DESIGN AND METHODOLOGY	67
Introduction.....	67
Purpose and Research Questions	68
Theoretical Framework.....	69
Phenomenological method	69
Phenomenology, Gestalt, and self-schema model.....	74
Data Collection	75
Research approval	76
Recruiting participants	76
Participants.....	77
Confidentiality	78
Method of Collecting Data.....	78
Interview Protocol.....	79
Data Analysis	81
Self-Reflexivity.....	83
Summary	84
IV. PARTICIPANTS	86
Interview Protocol Reflection.....	86
Participants' Stories	87
Scott.....	87
Demographics	87

Etiology.....	87
Treatment	89
Maintenance/Recovery	90
Jay.....	91
Demographics	91
Etiology.....	91
Treatment	92
Relapse.....	92
Treatment	93
Maintenance/recovery.....	94
Casey.....	94
Demographics	94
Etiology.....	94
Treatment	96
Relapse followed by treatment.....	96
Relapse number two followed by treatment	97
Relapse number three followed by treatment	97
Maintenance/recovery.....	98
Michael.....	98
Demographics	98
Etiology.....	99
Treatment	101
Relapse and treatment.....	101
Treatment challenges.....	101

Relapse number two and treatment.....	102
Relapse number three and treatment.....	102
Treatment challenge	102
Maintenance/recovery.....	103
Chris.	103
Demographics	103
Etiology.....	103
Treatment	105
Maintenance/recovery.....	106
Addressing issues of masculinity.....	106
Edward.....	107
Demographics	107
Etiology.....	107
Treatment	109
Relapse and treatment.....	110
Maintenance/recovery.....	110
Disclosing diagnosis to others	111
Eating disorder stigma	112
Additional participants	114
Summary	116
V. FINDINGS AND ANALYSIS	118
Interview Introduction	118
Creative Adjustment	119
Self-Concept Disturbances.....	120

A Sense of Belonging	123
Theme Identification.....	124
Data Analysis	126
Etiology	126
Family/genetic influences.....	131
Peer influence.....	131
Media influence.....	132
Cultural influence.....	133
Trauma-related influence.....	134
Physical/body awareness.....	134
Personality traits.....	135
Etiology common themes review.....	139
Etiology summary.....	143
Treatment.....	143
Negative aspects of treatment	145
Relapse	147
Therapeutic alliance	148
Therapeutic tools.....	149
Treatment summary	150
Recovery/maintenance	151
Negative aspects.....	153
Positive aspects	153
Recovery/maintenance summary	156
Summary.....	157

VI. DISCUSSION.....	159
Introduction.....	159
Summary of Common Themes	160
Etiology	160
Treatment.....	165
Recovery/maintenance	166
A Comprehensive Theme	168
Limitations	171
Future Research	174
Implications for Practice.....	177
Conclusion	179
REFERENCES	182
APPENDICES	205
A. INFORMED CONSENT FORM.....	206
B. RESEARCH INFORMATION SHEET	208
C. PARTICIPANT CHARACTERISTICS AND DEMOGRAPHICS SURVEY	209
D. INTERVIEW TRANSCRIPTS AND RESEARCHER’S JOURNAL EXCERPTS	210
E. RESEARCH AND INTERVIEW QUESTIONS.....	247

LIST OF TABLES

1.	Participant's age of onset and diagnosis.....	126
2.	Participant's meaning making quotes and etiology themes drawn from the participants' interviews.....	128
3.	Treatment type and themes drawn from the participants' interviews.....	144
4.	Recovery/Maintenance stage of each participant and themes drawn from the participants' interviews.....	152

LIST OF FIGURES

Figure 1. Variations of bipolar continuums of contact style. (Clarkson, 2004, p. 60-67; Joyce & Sills, 2010, p. 107; Mackewn, 1997, p. 28, 107)	17
Figure 2. Continuum from feeling invisible at the development of an eating disorder to feeling seen in recovery.....	158

CHAPTER I

INTRODUCTION

*The spirit cannot endure the body when overfed,
but, if underfed, the body cannot endure the spirit.*

~ St Frances de Sales

The Good Eater (Saxen, 2007), *A Starving Madness* (Rabinor, 2002), *Making Weight* (Andersen, Cohn, & Holbrook, 2000), *Hungry* (Zadoff, 2007) and *Feeding the Fame* (Stromberg & Merrill, 2006) are just a few of the titles presenting the lives of individuals diagnosed with anorexia nervosa, bulimia nervosa, and other eating disorders. These narratives and many others demonstrate the degree to which a preoccupation with weight, diet, and body image are precursors in developing an eating disorder. In comparison to only five texts available in the 1970s, published titles concerning eating disorder topics have exploded with more than 500 titles available today (Andersen et al., 2000). The majority of these texts reflect the experiences of women living in a world that favors a thin ideal; however, the sheer numbers of published female accounts falsely conveys an impression that eating disorders are solely a female issue.

The National Association of Anorexia Nervosa and Associated Disorders (ANAD), stated on their website that “up to 24 million people of all ages and genders

suffer from an eating disorder (anorexia, bulimia and binge eating disorder) in the U.S.” (National Association of Anorexia Nervosa and Associated Disorders, n.d.), a statistic acquired from a 2003 report distributed through The Renfrew Center Foundation for Eating Disorders. The research has indicated that children as young as age 7 have reported a fear of becoming fat and begin exhibiting dieting behaviors which intensify during adolescence (Harrison & Hefner, 2006; Moriarty & Harrison, 2008). This seems to be the case for males, as well as females, per the report by Hudson, Hirii, Pope, and Kessler (2007) in which they found 28% of male adolescents fast, skip meals, vomit and/or use diet pills and laxatives to control their weight. While women have always experienced a social pressure to appear physically attractive, now men are also reporting body image concerns and exhibiting an increased focus on having an “ideal body,” such as that portrayed in the mass media (Bunnell, 2010; Maine & Bunnell, 2008). While much of the research focus has been with females, there is cause for concern that the male population suffering from eating disorders has the potential to equal the number of reported cases of females.

In her review of epidemiological studies, Costin (2007) found many discrepancies in providing statistical data on the incidence and prevalence of eating disorders, due to the varying ways research has been conducted. Prevalence and incidence data aid in identifying patterns, possible causes, effects of the disease and the populations affected by the disease. Prevalence refers to the actual existence of the disease and how many individuals out of 100,000 have been diagnosed. Incidence refers to the frequency of the occurrence; incidence data demonstrates the extent eating disorders have increased over the years.

The typical statistics quote a 10 to 1 ratio, meaning that for every 10 women diagnosed with an eating disorder, 1 male is diagnosed. However, recent research has suggested a higher incidence of reported eating disorders among the male population than has been reported in the past. According to Andersen et al. (2000), men account for one in six cases. More alarmingly, only 16% of those men suffering with an eating disorder will seek treatment (Freeman, 2005). According to Menstuff® (2012), men are often not diagnosed and/or are embarrassed by being diagnosed with an eating disorder, because eating disorders have become more known as a women's problem. Furthermore, homosexual males are incorrectly reported as having higher incidences of eating disorders when, reportedly, 80% of men with eating disorders are heterosexual (Feldman & Meyer, 2007; Menstuff®, 2012). Athletes (male and female), in general, have a higher incidence of eating disorders due to the weight restrictions required by their sport (Bunnell, 2010); however, the increased incidence of eating disorders continues to rise across the population outside of individuals participating in athletic sports.

Two ideas are most often expressed in explaining the lack of research and inconsistent statistical data regarding men with eating disorders (Feltman & Ferraro, 2011; Støving, Andries, Brixen, Bilenberg, & Hørder, 2011). The first idea has already been introduced in that eating disorders have been stereotyped as a female disorder. The second theory points out that the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) ruled out the possibility that men might have an eating disorder by the limiting criteria, such as amenorrhea in postmenarcheal females must be present for a diagnosis of anorexia nervosa (AN) and body weight must measure less than 85% of the expected weight for one's age and

height. One man reported he was not admitted into a hospital day program because he did not meet the weight criteria (Drummond, 2002). Men tend to have a shape goal, not a weight goal and therefore, not meet the weight criteria (Andersen et al., 2000).

Not only are symptoms generally associated with women, but the diagnostic criteria are as well (Andersen, 1990; Costin, 2007; Feltman & Ferraro, 2011; Freeman, 2005). “The spectrum of body image and eating problems appears in every economic, racial, and ethnic stratum of American culture and in at least 40 countries worldwide, including places as unlikely as China, India, Mexico, Nigeria, South Africa, South Korea, and the former Soviet Union” (Gordon, 2000, as cited in Costin, 2007, p. 36). Eating disorders are non-discriminate, affecting both genders, all age groups, and across all backgrounds. Per the literature, female adolescents appear to be the highest at-risk population for developing an eating disorder, but that should not translate to mean they are the only group requiring research and intervention.

Overall, individuals with an eating disorder are less likely to seek treatment due to the secretive nature of the disease (Pettersen, Rosenvinge, & Wynn, 2011). Add the significant bias and stereotypical belief that eating disorders are a “female problem” (Soban, 2006) to the reluctance men have in seeking treatment, it is not surprising that definitive statistics are very difficult to procure (Costin, 2007; Freeman, 2005). According to Andersen et al. (2000):

...preoccupation with weight, shape, and appearance, and eating disorders have... been called ‘women’s issues.’ Men with these kinds of conflicts have felt stigmatized, and they have been largely excluded from diagnosis and treatment (p. xiii).

Andersen et al. (2000) estimated 25%-30% of eating disorder patients are male but additional research is necessary to verify this data.

While the literature reflects statistical disparities, all of the current research indicates a dramatic increase in the number of reported patients with eating disorders in all populations worldwide. Hoek and van Hoeken's (2003) literature review analyzing eating disorders incidence and prevalence rates included epidemiologic studies from Western Europe and the United States. Their study confirmed that the number of cases substantially increased since 1935 and the diagnosis of bulimia tripled between the years 1988-1993 (Hoek & van Hoeken, 2003), seemingly coinciding with the increase in the promotion of a thin ideal (Costin, 2007). In her extensive research reviewing epidemiological studies, Costin (2007) noted one study that took place over a 50-year period from 1935 to 1985 reporting that "the overall prevalence for anorexia nervosa was 306 per 100,000 for females and 22 per 100,000 for males" (p. 25). Prevalence reports on bulimia nervosa vary, but there is clear evidence the incidence rate is three times greater today in comparison to when the disease was first discussed in Russell's 1979 seminal work (Costin, 2007). Anorexia and bulimia nervosa are the two most often studied eating disorders; prevalence and incidence rates for other eating disorder diagnoses are obscure and an area requiring further investigation.

The National Association for Males with Eating Disorders (NAMED, 2011), cited several research studies indicating "a rise in the incidence of eating disorders in males" (Statistics section, Research sub-section, para. 3). These include:

1. University of Toronto study, completed in 2000, indicated one out of every six participants who qualified for an anorexia nervosa diagnosis were male;

2. A large-scale survey funded by the National Institute of Mental Health (NIMH), conducted by Hudson and associates from 2001-2003, found that the ratio between male and female eating disorders respectively was 1:3, a substantial change in comparison to the National Eating Disorder Association's (NEDA, 2010) comparison of 1:10, a statistic that has been reported since 1995;
3. Woodside et al. (2001) indicated "the prevalence rate (weighted) of full or partial eating disorders for men was 2.0%, compared with 4.8% for women. The female-male ratio of full or partial syndrome anorexia nervosa was 2.0:1; for full or partial syndrome bulimia nervosa, it was 2.9:1" (p. 571). In other literature, researchers made known that the diagnosis of binge eating disorders in males was almost at an equal rate as in women (Andersen et al., 2000; Costin, 2007).

Anorexia nervosa has the highest premature fatality rate of any mental illness and the highest suicide rate of any mental disorder (Academy for Eating Disorders, 2010; Costin, 2007; National Institute for Health and Care Excellence, 2004; Sullivan, 1995). As with all the statistics available on eating disorders, death rate data varies, but all conclude the mortality rates are high (NEDA, n.d.). Some studies reported bulimia nervosa and the diagnosis of eating disorder not otherwise specified, have a lower death and suicide rate (Costin, 2007), while others reported mortality rates similar to those for anorexia nervosa (NEDA, n.d.). Additionally, the medical complications that individuals with an eating disorder develop are many, including cardiovascular, dermatological, skeletal, and metabolic complications (Glover & Sharma, 2012), and are equally

disruptive in one's ability to fully experience physical and mental wellness (Costin, 2007).

Medical complications, such as heart disease, once diagnosed, cannot be reversed manifesting life-long medical issues and the financial burden attached to medical care. Morris (2012) reported "some individuals with eating disorders can live with their illness and engage in successful occupations, although their social performance, especially in relation to eating, is usually affected" (p. 61). For example, severe eating restriction prevents individuals with an eating disorder from engaging with others where food may be involved, such as holiday feasts, family reunions, work retreats, and other social pursuits. To avoid food, individuals with an eating disorder will disengage from socializing by isolating self, avoiding and withdrawing from interaction with others furthering depressive symptoms and eating disorder rituals (Morris, 2012). An individual's ambivalence to engage in social and work activities may have a connection with one's need to feel in control.

Individuals with an eating disorder share one common resolve: a need to feel in control (Kitson, 2012). According to Jantz and McMurray (2010):

Eating disorder behavior at first gives the sense of being in control, producing a feeling of emotional power. The greater the emotional power, the greater the false sense of control. We feel in control, so we continue the behavior. The more we continue the behavior, the more we feel in control. Feeling in control gives us a sense of power. (p. 42)

It is important to understand these shared experiences in order to develop preventive measures. Considering that one out of every three dieters is at risk for

developing an eating disorder (NEDA, 2010), this is a topic of great interest and concern. Valois, Zullig, Huebner, and Drane (2003) reported on the “counter-productive, often harmful” (p. 272) effects of dieting. There is research that has suggested the anxiety that drives the fear of becoming fat and the constant restrictive dieting behaviors may be more than risk factors, but the early onset stages of an eating disorder (Valois et al., 2003). Additional risk factors noted in the literature include media messages, peer influences, family dynamics, negative affect, low self-esteem, body dissatisfaction as well as cognitive and biological aspects (Polivy & Herman, 2002).

While the literature is abundant with data regarding risk factors and symptoms, very little is known about the healing factors contributing to recovery from an eating disorder (Pettersen et al., 2011) and few preventive measures are researched. For those under medical care, the treatment is long and the recovery numbers are humble (Björk & Ahlström, 2008); developing a deeper understanding about the characteristics of this phenomenon will aid in the continuing development of the best treatment practices including those for boys and men.

The intention of this dissertation is to provide insight into the males’ experiences as a means to help clinicians recognize the function an eating disorder has on one’s identity, on one’s sense of control, and on one’s interpretation of their quality of life.

Conceptual Underpinnings for the Study

In reviewing the literature, several broad theories have been used in an attempt to explain eating disordered behavior including social psychological theories, psychodynamic theories, and developmental models. In addition to these, the literature also attributes body image dissatisfaction and the onset of eating disorders to a multitude of

factors, including social pressures to conform to a thin ideal in which sociocultural theories were applied (Cafri et al., 2005b; Cusumano & Thompson, 1997; Groesz, Levine, & Murnen, 2002; Moriarty & Harrison, 2008; Morrison, Kalin, & Morrison, 2004; Stice, 2001; Stormer & Thompson, 1996; Tiggemann & Slater, 2004); family influences in which attachment styles and family dynamics were related (Koskina & Giovazolias, 2010; Minuchin, Rosman, & Baker, 1978; Ravi, Forsberg, Fitzpatrick, & Lock, 2009; Whitney et al., 2005); co-morbidity factors, such as mood disorders and emotional dysregulation due to feelings like shame, anger, anxiety, and depression that have been associated with eating disorders (Allan & Goss, 2012; Fox & Power, 2009; Goss & Allan, 2009; Meyer et al., 2005; Peñas-Lledó et al., 2004; Whetstone, Morrissey, & Cummings, 2007); and self-identity and effectiveness theories (Bruch, 1973; Garner, Vitousek, & Pike, 1997; Goodsitt, 1997; Onorato & Turner, 2004; Stein, 1996).

Eating disorders are most prevalent in societies where food is abundantly available and a thin body ideal is valued (Freeman, 2005; Polivy & Herman, 2002). Polivy and Herman (2002) reviewed the literature for contributory factors (sociocultural influences, familial characteristics, and individual risk factors) of eating disorders. They concluded of all the elements tested, environmental stressors (e.g., physical abuse) and obsessive thoughts (e.g., constant worry about weight and body shape) appeared to be precursors for an eating disorder. Furthermore, personality characteristics (e.g., need to feel in control) and a weak identity formation, were the most plausible elements in explaining the development of an eating disorder. While many individuals diagnosed with an eating disorder present with negative affect, a high level of body dissatisfaction, and low self-esteem, many people without eating disorders present with similar

characteristics (Polivy & Herman, 2002). The same holds true for risk factors like dieting and other weight loss activities; for some individuals, these behaviors are reportedly a precursor to eating disorders (Polivy & Herman, 2002; Ricciardelli & McCabe, 2004), but without further evidence, the behaviors cannot be deemed a cause for an eating disorder.

While there is much speculation as to the etiology of eating disorders and a growing list of risk factors, there is no central, clear cause. The field of social psychology applies specific theories to explain social and cultural phenomenon. Barlett, Vowels, and Saucier (2008) compared two models: the tripartite influence model and Cafri et al. (2005a) model. The tripartite model suggests parents, peers and media are influential in shaping body image attitudes. The relationship of these mediating forces and eating pathology is theorized to stem from the internalization of the ideal appearance of the human body -- a thin ideal for women and a muscular ideal for men (Ricciardelli & McCabe, 2004) – and appearance comparisons affecting an individual’s self-concept (Smolak, Murnen, & Thompson, 2005). The incurred negative self-image, manifested by way of internalizing a social ideal and/or comparing one’s own body to others and/or media depictions, will lead to engagement in risky body change behaviors (e.g., steroid use) even to the point of injury (Barlett et al., 2008; Smolak et al, 2005). The Cafri et al. (2005a) model is similar, in that individuals are impacted by the societal factors noted in the tripartite influence model, but include biological development factors; for example, males reaching puberty early are identified at risk in developing an eating disorder (O’Dea & Abraham, 1999). Cafri et al. (2005a) further examined the effects of teasing and perceived popularity on social body comparison, which impacts body image

dissatisfaction and ultimately, behaviors, like steroid use and body building to increase muscularity, which are used in coping with body image disturbances (Cafri et al., 2005a).

Psychodynamic theories raise awareness of the role unconscious conflicts and motivations have in the development and sustainment of eating disorder behaviors. Freud (1937) initiated the concept of psychological defenses including: (a) regression in which an individual deals with development anxiety by reverting to a lower level of development. Maturity fears are a known risk factor in the development of anorexia nervosa (Crisp, 1997; Strober, 1997); and (b) reaction formation is when behaviors express the exact opposite of how one really feels or thinks about a phenomenon. The anorexic constantly thinks about food and often distracts from the sensation of hunger, but will refrain from eating.

Goodsitt (1997) reviewed three main by-products of psychodynamic theory: drive-conflict model, object-relations theory, and self-psychology. In the drive-conflict model, the individual is in conflict internally with external factors; for example, self-starvation is a defense against having sexual desires. Object relations theory is linked to the organizing knowledge one has of self and of other people. The psychodynamic theories refer to “other” as “object” to distinguish self from another. One’s representation of how they get along with others is known as the internal object relations (Mahler, 1968). Object relations and the central symptoms of eating disorders represent conflict around relationships; the restrictive dieting is thought to represent a struggle for autonomy and control (Bruch, 1973; Goodsitt, 1997). Self-psychologists emphasize developmental factors in the eating disorder individual’s lack of success in acquiring various self-regulating functions and maintaining a good level of self-esteem. “The

absence of reliable internal self-regulation results in the anorexic's feeling inadequate, ineffective, and out of control – expressed as feeling fat” (Goodsitt, 1997, p. 209).

Developmental models further explain growth deficiencies from a cognitive viewpoint.

Piaget's (1929, 1987a, 1987b) model may help to explain the possible underlying dysfunctional mental processes for the development of an eating disorder. Piaget was concerned with child development as it pertained to social, intellectual, emotional, and moral development. Relations with others and interactions in the environment influence all aspects of development. Personality is developed, the self-defined, through the interpretations and schema organization of the individual's experiences. Social reciprocity involving mutual engagement and valuing is a core element of emotional and personality development according to Piaget. When these thoughts become representational, values, ideas, and beliefs become more fixed. Smolak and Levine (1994), influenced by Piaget's theory, suggested childhood attitudes about body image are organized into body schemas based in social and cultural learning experiences, such as family diet values, peer modeling, and media influences. The way earlier experiences were organized by the cognitive processes of the brain may predict the viability of adaptations during developmental transitions. Individuals who were teased about weight and/or physical features are known to be at a higher risk for developing eating disorder behaviors during developmental transitions like adolescence (Kearney-Cooke & Steichen-Asch, 1990).

Stein (1996) suggested considering the self-schema model to aid in the understanding of values, beliefs, and ideas individuals with an eating disorder support and what their body schema might explain regarding their body-mind relationship. Piaget

(1932) and Bartlett (1932) are credited for introducing the notion of schemas into psychology. Piaget's view supports cognitive psychology. In his model of cognitive development, Piaget demonstrated the process by which we gain knowledge, referring to assimilation and accommodation. New information, that in some way is familiar to an individual, is assimilated into a pre-existing schema; for example, one might have a framework for produce, so when a new vegetable is introduced, that vegetable would be assimilated into the schema one has for produce. Accommodation requires modification to an existing schema or the formation of a completely new schema in order to cope with the new data. For the person with an eating disorder, developing healthier attitudes about food will require accommodation; initially, this state will frustrate a person until their cognitive equilibrium is restored.

Bartlett's (1932) view supports existentialist psychology. His model demonstrated how individuals reconstruct long-term memories so that schemas are interpreted to reflect current beliefs and ideas. For example, when the British fashion model, Twiggy, first appeared in advertisements in the mid-1960s, most people described her thin figure as sickly; while today, her figure would be deemed an ideal body type and individuals may report their original memories in a more positive frame. Schemas are identified as being dynamic cognitive constructs. With awareness training, individuals can play an active role in adapting new schemas.

Theoretical Framework

For this dissertation research, this section of Chapter I begins with a theoretical explanation based in a self-schema model. Markus (1977) first proposed this model and continued to adapt this approach to body image (Markus, Hamill, & Sentis, 1987). This

model is adapted here to help explain the behaviors, thoughts and feelings that accompany an eating disorder.

Individuals with an eating disorder tend to be exceedingly critical of their body weight and shape especially in comparison to people without an eating disorder. Awareness of self-concept, discovering the degree to which constant self-assessment and negative self-perception is experienced, can aid in recognizing the extent one's thought patterns impede on their quality of life and exacerbate eating disorder behaviors. In addition, beliefs individuals have regarding their self-esteem, anxiety, control, and success may inform how these and other personality traits are connected to maintaining eating disorder behavior. Stein (1996) stated:

Within this framework the self-schemas may be considered the critical mediating variables for explaining how aspects of the immediate interpersonal and broader sociocultural environments... impact processes of self-regulation and behavior. (p. 106)

Patterns or schemas are formed based on sensory information we receive from the environment. Regardless of the theoretical model used, sensory perception or sensory input is the initial proponent to gaining knowledge. It is from this input that we learn to pay attention, we form memories, we gain information, we learn language, and we gain reasoning and problem solving skills. Schemas reflect how one organizes that information. Once formed, they are held in long-term memory, most often outside of one's awareness. Self-schemas are formed in a multitude of domains including worldviews, social roles, and body schemas. We draw on our schemas to inform our interactions with the environment (Stein, 1996).

There are different models that attempt to explain how schemas are formed; earlier Piaget's model was briefly discussed explaining how we assimilate or accommodate new information with pre-existing schemas. Cognitive Behavioral Therapy (CBT) addresses how thoughts of negative self-perceptions can cause one to experience unpleasant feelings and/or negative behaviors (Cash & Pruzinsky, 2002). Using behavioral modifications, individuals are assisted in correcting dysfunctional thinking and modifying perceptions. In the treatment of eating disorders, this approach is aimed at normalizing meals and food choices and adapting healthier attitudes about food, body image, and self-perception.

The Gestalt approach. Another approach comes from Gestalt therapy. Gestalt literally means form or shape and captures the notion that an organized whole is greater than the sum of its parts. This approach sets out to discover what rules we use in organizing the components to perceive the whole. The figure-ground illusions contributed from Gestalt psychology demonstrate the stability of our perception and also our misperceptions. The Gestalt foundation of promoting awareness "is the energy for assimilation and growth at the contact boundary, for self-knowledge, choice, and creativity" (Joyce & Sills, 2010, p. 31). "Awareness is a form of experiencing" (Clarkson, 2004, p. 39) accessed by way of paying attention in the present moment to one's subjective experience. This involves being curious about sensory, emotional, cognitive and physical information without judgment (Clarkson, 2004; Mackewn, 1997).

Cycle of experience. According to the Gestalt approach, perception is transpired by way of combining elements or sensations. Once a sensation is perceived, it becomes figure while the surroundings become ground or less prominent. This process is cyclic

and constant, as it is the means of being in relationship or in contact with one's surroundings. In Gestalt theory, this cycle is self-regulating with modifications made as the field conditions change. Most often, individuals are not mindful to sensations, and responses become automatic. By going through a cycle of experience, the detailed account of contact can be better described and a greater awareness of self can be attained. Zinker (1977) described the cycle as:

The power of this description is that it gave greater depth and understanding to figure/ground formation. The figure would surface during **sensation**, where the individual experiences something happening that disturbs the steady state. If the **sensation** holds sufficient attention of the individual, **awareness** of a need would sharpen. **Awareness** begins to develop through a mixture of feelings, thoughts, perceptions that seek to interpret the sensation. **Energy** mobilizes in response to this awareness of a specific need that is seeking satisfaction. The energy is released and **Contact** is made with that which will satisfy the need. During **contact**, whatever is other than the self is digested by destructuring to find what is new or different and assimilating (or integrating) it. When what is new or different has been satisfactorily destructured and assimilated, change occurs within the organism (individual). Once the original need has been satisfied, the individual returns to a steady state by **withdrawing** from the experience and **closing** the cycle. When the cycle has been completed, the individual would return to sensation and wait for a new figure to emerge from the fertile ground of the individual. (p. 90-91)

Gestalt contact styles. In addition to the cycle, contact styles may help explain eating disorder behaviors. Contact styles are patterns of response that have been learned and exemplify varying ways of meeting and managing sensations. These include desensitization, deflection, introjection, projection, retroflexion, egotism, and confluence. These styles are a function of self-regulating and represent the path of least resistance or ways of being in contact. “One cannot destroy resistances; and in any case, they are not an evil, but are rather valuable energies of our personality harmful only when wrongly applied” (Perls, 1969, p. 153). These resistances are sometimes referred to as ‘modifications to contact’ (Joyce & Sills, 2010, p. 106) and represent the creative adjustments made to address the challenges that arise as part of the human condition. At either end of the spectrum, each contact style has the potential to interrupt or support contact depending upon the particular field conditions at any time. Figure 1 shows how the “bipolar continuums of contact style” (Mackewn, 1997, p. 28) has been displayed in variations such as:

Desensitization:	numbing, minimizing..... hypersensitivity, sensation flooding
Deflection:	avoiding/reducing contact, indirect.....direct, assertive, focusing
Introjection:	swallowing whole.....deconstructing, rejecting
Projection:	blaming, disowning.....imagination, owning, literalness
Retroflexion:	withholding impulses.....unrestrained expression
Egotism:	self-monitoring..... non-reflection
Confluence:	connecting, merging.....differentiating, isolating

Figure 1. Variations of bipolar continuums of contact style. (Clarkson, 2004, p. 60-67; Joyce & Sills, 2010, p. 107; Mackewn, 1997, p. 28, 107)

These regulatory contact styles are measured on a continuum depicting one’s level of flexibility to cope with new situations.

Desensitization. Another word for desensitization is “numbing” or diminishing emotional responses as a way of avoiding contact to sensations. This becomes problematic when sensations and feelings are ignored to the extent the mind-body relationship becomes disconnected. At the very extreme, an individual loses the ability to fully take care of self, such as the severe anorexic. The polar opposite of this is over-sensitizing. In this case, the individual is preoccupied with sensations and feelings. Problems that arise from this extreme include compassion fatigue and hypochondriasis.

Deflection. Individuals deflect when they want to avoid contact by reducing awareness of the emotional impact of a situation. Reducing awareness may be accomplished by a shift in attention, changing the subject, being indirect, or using humor/laughter. When this becomes habitual, feedback from self or others cannot get through; thus, avoiding criticism, but it also prevents love and recognition to be heard or felt leaving the individual feeling isolated and alone. The opposite pole is acceptance, bringing about a peaceful, non-judgmental mindset. In psychotherapeutic treatment, one goal of therapy might be to foster acceptance. At either end of the continuum, dysfunction may present. In the case of acceptance, being overly open and receptive to experience may result in becoming overwhelmed and indecisive.

Introjection. This contact style is often explained as swallowing whole an opinion, attitude, or rule without considering the validity of the claim. Introjects are often meant for the greater good; for instance, messages parents give to their children like “finish your food because there are starving kids elsewhere” to prevent food waste. However, people who habitually use this contact style exhibit low self-directedness and tend to keep an eye out for what they should be doing. Rather than making discriminating

decisions, this leads to the willingness of having beliefs imposed upon self. The polar opposite of introjection is rejecting in which if the opinion, attitude, or rule does not fit with the individual's values, it will be rejected. This becomes problematic when every idea is rejected and presents as overly skeptical, rebellious, or self-reliant.

Projection. Projection is discussed in several ways. One way is in the sense an artist projects their imaginative and creative vision onto different art forms such as the canvas, film, theater, or novel. Another way is transference or the redirection of feelings being projected on to another; for example, the therapist becomes a parent figure for the client. And then, there is this way of looking at projection: the disowned feelings or parts of self-incompatible with one's self-concept. Instead of owning the experience, the individual projects it onto someone else or places blame on other. The polar opposite is owning or taking responsibility for one's experience. A cornerstone aspect of Gestalt Theory; however, owning can also be taken to the extreme such as when it paralyzes self with guilt or remorse.

Retroflection. Retroflection is withholding emotions or actions intended for other people. This may have been learned in childhood when feelings and thoughts were not validated or consequences were given for expressing natural impulses. When impulses are inhibited, the energetic flow or retroflection can result in varying ways such as bodily tensions, psychosomatic illnesses, depression, or self-harm. At the opposite end of this continuum is impulsiveness or unrestrained expression.

Egotism or Self-Monitoring. Self-reflection and reflexivity are healthy patterns of behavior; however, an excessive preoccupation with one's own thoughts, feelings, and behaviors can become narcissistic or overly self-critical. Either way, contact is avoided as

a result of appearing disinterested in the input of others or coming across as arrogant. Individuals using this contact style are generally self-centered and tend to control the conversation. Non-reflection or spontaneity is the polarity, which at the extreme, may result in thoughtlessness and stepping outside safe boundaries.

Confluence. Confluence is the inability to differentiate between self and other. In this contact style individuals have difficulty either with attachment or with separation. In relationship, there are times when it is beneficial to be confluent; for instance, to get along in a group. However, a persistent drive to be confluent leads to a loss of self. Differentiating is the polar opposite; when an individual over-differentiates; they report feeling isolated and not a part of the world.

Contact styles reflect the way in which an individual responds to the field, the contact point where the individual meets the situation and responds in a way that is satisfying. “This contacting or meeting is a continuous process but needs to be regulated or modified according to the field conditions in each unique situation” (Joyce & Sills, 2010, p. 105). The individual with an eating disorder exhibits a fixed Gestalt, or fixed way of contacting with relationship to food involving passively chewing or rejecting nourishment. This exemplifies introjection. “Introjection involves taking into our system aspects of the environment (such as food or ideas) without assimilating them” (Mackewn, 1997, p. 27). How and when individuals regulate contact on the cycle of experience is individually expressed.

Gestalt approach summary. The cycle of experience can help illustrate one’s capacity to gain an accurate and intuitive understanding of how individual needs are fulfilled or interrupted. In this way, the individual is empowered to experience a natural

ability to self-regulate and a greater possibility for growth and development. Using this model, issues of identity and self-definition can be better defined and measured, analysis of how various factors function together in the formation of the eating disorder can be gathered, and how external influences (e.g., sociocultural environment) contributed to one's internal messages regarding body shape and physical attributes (e.g., weight, muscular build) can be specified.

Stein (1996) reported that most eating disorder interventions are focused on changing maladaptive thinking; however, validating current thinking and identifying hidden strengths may promote new perspectives and a natural schematic change. The Gestalt view is considered a field-theoretical approach, but can complement the cognitive approach to understanding schemas (Tønnesvang, Sommer, Hammink, & Sonne, 2010).

The modern view is that all bodily-based sensory and emotional structures are linked to cognitive structures, which are seen as schemas. Schemas are the core organizing units of cognition. Instead of linear processing, the cognitive perspective focuses on the parallel processing of informant. This means that there are multiple networks operating at any one time, with numerous possible gestalts that could emerge... The raw stimuli of the field are processed/experienced through these schemas that act as frameworks in that they link emotive, sensory, and cognitive structures... schemas can be viewed as the contemporary version of gestalts. Following this view, schemas can be thought of as the underlying process or figure formation . . . this corresponds closely to the Gestalt concept of insight. (Fodor, 1998, 56-57)

In addition to offering a foundation for understanding the resistant nature of eating disorder behaviors and offering a therapeutic model for working with resistances, the Gestalt approach also provides support for exploring human experiences with a phenomenological methodology. This dissertation study, learning more about males' experiences of eating disorders, incorporates a phenomenological stance.

Review of Therapeutic Approaches

In the 1990s, a heated debate developed over what constitutes evidence for psychotherapy effectiveness and efficacy. The recommendation for implementing evidence-based practice, in part, was promulgated by the rising health costs in managed care and increased accountability for treatment decisions. A Google search revealed there are approximately 200 psychotherapy approaches, yet with so much focus on evidence-based practice one has the impression that behavioral therapies, specifically Cognitive Behavioral Therapy (CBT), are the only approaches. Hubble, Duncan and Miller (1999) built a strong case in their text, *The Heart and Soul of Change*, demonstrating that therapeutic alliance and client variables have a greater impact on positive outcomes than theoretical technique. Furthermore, behavioral approaches best lend themselves to empirical study, as the variables being tested are observable and measurable. However, it is a far stretch to assume CBT, for example, is the most effective treatment when it is the only one being sampled (Reed & Eisman, 2006). Furthermore, investigations completed in a controlled environment often do not replicate the challenges clinicians face in practice (Carter, 2006). While some specific techniques look promising in the treatment of certain pathologies (Asay & Lambert, 1999), "change is more likely to be long lasting

in clients who attribute their changes to their own efforts” (Lambert & Bergin, 1994, p. 27).

The clinical guidelines in the treatment of eating disorders are published by the National Institute for Health Care Excellence (NICE, 2004) and were developed to inform clinicians on the diagnosis, treatment, and management of eating disorders. Several recommendations were made, such as monitoring a patient’s vital signs and physical status as part of treatment intervention. The guide acknowledged the gaps in research; research recommendations were also included. Based on the collected evidence, the guide suggested the following approaches to be considered for treatment: cognitive analytic therapy (CAT), cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions designed for the eating disorder patient. In a summary of studies on the efficacy of these various treatments, outcomes indicated comparative effectiveness (Fairburn, 2008; NICE, 2004). It is further recommended that the goals of treatment include restoring weight, acquire healthy eating habits, and reduce any other eating disorder related symptoms (NICE, 2004). Treatment is heavily focused on repairing one’s physical state and cognitions related to diet and body concerns. Even though the literature recognizes low self-esteem and poor interpersonal confidence as impactful factors, recommendations to address self-concept disturbances appear less important; more research is necessary to determine the degree in which self-concept beliefs and attitudes need to be explored in addition to the eating disorder symptoms.

Andersen (1990), Director of The Eating and Weight Disorders Clinic in Baltimore, Maryland, emphasized the importance of “nutritional rehabilitation” as

necessary at the beginning and throughout treatment. Food is the medicine for individuals with an eating disorder. If a patient's weight is within the normal ranges at admission, nutritional support is still advised; patients "have usually developed elaborate "approach-avoidance" patterns toward food in general or toward specific, feared foods..."

(Andersen, 1990, p. 148).

Per Andersen (1990), psychotherapy has three main elements:

1. Central Dynamic Formulation: this involves identifying specific themes in patients. From these themes, the overarching purpose the eating disorder serves in the patient's life is organized into a succinct statement. Themes may include past experience with obesity, defensive dieting to avoid health problems that one's parents may have suffered, and sports-related dieting (p. 149).
2. Multimodal Format, which integrates individual, group, and family counseling.
3. Meeting the needs of the patient. "We find that the most helpful psychotherapy sequence begins with supportive and educational psychotherapy, followed by cognitive-behavioral work, leading to psychodynamic psychotherapy, and finally to existential psychotherapy" (p. 150).
 - a. Cognitive-behavioral approaches are used to challenge the maladaptive thinking, such as all-or-none reasoning, catastrophizing, overvaluing body ideals.

- b. Psychodynamic Psychotherapy helps patients increase their awareness of symptoms, recognize how they make meaning of their eating disorder, and develop personal stability and responsibility through a here-and-now approach.
- c. Existential psychotherapy focuses on identity issues and encourages generating a purpose for living

Education is a very important aspect of treatment, especially in the area of nutrition. Once weight is restored and individuals exhibit less distorted thinking, treatment focuses on the transition from being compliant in the program to making healthy choices outside of treatment. Role playing helps individuals to gain confidence in anticipating social situations. “Males, in general, need assistance in coping with a different kind of cultural pressure and stereotype than that faced by women with eating disorders” (Andersen, 1990, p. 158). Symptoms and effects associated with malnutrition are similar for both sexes, but the return of testosterone to normal levels and reawakening of the sex drive is unique to men with an eating disorder. Additionally, vulnerabilities around different social expectations for men regarding masculinity and a muscular image versus a thin image need to be addressed.

The treatment of males with eating disorders is not well researched; hence, this dissertation study expects to add to the literature, information about males’ attitudes toward treatment and the identification of most helpful and least helpful recovery processes.

Treatment Options

There are different levels of treatment available for individuals with an eating disorder. Outpatient treatment is suited for less severe cases and for relapse prevention. Individuals maintain their typical work and social schedules, as well as plan to meet regularly with members of their treatment team (e.g., nutritionist, internist, and therapist). Day hospital programs are an option for individuals having greater difficulties, but not able to manage the time and financial expense of an inpatient program. Day treatment programs provide psycho-educational classes, group therapy, nutritional counseling and meal support, and individual therapy. Depending on employment situations, individuals are able to continue working and sleep at home. Inpatient hospital programs generally serve to stabilize patients (e.g., refeeding treatment) and prepare individuals for transitioning into the next level of care. Usually, this is a relatively short stay in the hospital with a plan for ongoing treatment created before the patient is discharged. Residential treatment is for the most severe cases or patients were not successful at a lower level of treatment. In a residential facility, patients receive more intensive treatment over several weeks.

Most facilities are exclusive to women or have a co-ed program. This research hopes to learn the experience of men in the treatment of eating disorders alongside women. There are residential programs designed specifically for men, for instance, Rogers Memorial Hospital in Oconomowoc, Wisconsin; but they are only a few in number.

Definition of Key Terms

It is important to distinguish between disordered eating behaviors and an eating disorder. “Disordered eating and obsession with food is a widely accepted way to deal with weight and body image issues” (Hesse-Biber et al., 2006, p. 211). Body image dissatisfaction, dieting attitudes, and the pressure to be thin have been prevalent for so long that eating behaviors associated with an attempt to lose weight are considered normal (Haworth-Hoepfner, 2000; Levine & Murnen, 2009), complicating diagnosis and treatment. While there is strong evidence supporting the notion that disordered eating behaviors are directly related to sociocultural factors, it is believed that eating disorders develop due to a combination of factors including physical (e.g., maturation), biological (e.g., serotonin levels), psychological (e.g., depression), interpersonal (e.g., family and peer influences), and sociocultural issues (e.g., media exposure) (AED, 2010; Haworth-Hoepfner, 2000; Klump et al., 2010; Peterson, Paulson, & Williams, 2007; Polivy & Herman, 2002). On the surface it may appear that eating disorders are a preoccupation with food and weight, but in working with clients it becomes apparent that the eating disorder may also be a way of coping with distress. Individuals exhibiting negative feelings toward the physical body (e.g., shape, size) may have a vulnerable body-schema. “It is suggested that a limited collection of positive self-schemas available in memory, in combination with a chronically and inflexibly accessible body-weight self-schema, together lead to the onset and maintenance of the disordered behaviors associated with AN and BN” (Stein, 1996, p. 102).

The majority of disturbances in eating habits are characterized by an extreme fear of weight gain, which promotes extreme dieting behaviors. Individuals suffering from an eating disorder are consumed with thoughts about their size and shape and have an

intense drive to be thin. They often feel that their self-worth is dependent on their appearance. Struggling with an eating disorder can greatly affect the quality of one's life in that the individual becomes so consumed with the drive to be thin that their ability to function in other areas of life is severely hampered. The distinguishing feature of those suffering from anorexia nervosa is the refusal to eat and maintain a healthy weight while those suffering from bulimia nervosa engage in binge eating episodes followed by forced vomiting and the abuse of diuretics, laxatives or other amenities that will quickly discard calories. Both anorexia nervosa and bulimia nervosa can include the symptom of distorted perception of body shape and a strong sensitivity to weight (APA, 2000).

Disordered Eating. Disordered Eating may include any of the following: restrictive dieting, excessive exercising, binge eating and/or the use of aperients. In contrast, *Eating Disorders*, such as anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified, are clinical diagnoses. While an individual's actions may emulate that of someone with an eating disorder diagnosis, other psychological features typically associated with individuals suffering from an eating disorder may not be present. This growing population is identified as having imitative anorexia or a preoccupation with their weight (Hesse-Biber, Leavy, Quinn, & Zoino, 2006).

Anorexia Nervosa (AN). In simplest terms, this disease can best be described as an individual refusing to maintain a normal weight. The current DSM-IV-TR (APA, 2000) lists four criteria, which must be present for an anorexia nervosa diagnosis. These include:

- Criterion A includes the individual's body weight is being maintained with intention at a number below normal for that person's age and height or there is

an absence of normal developmental growth/weight gains. Body weight less than 85% of expected normal numbers is indicative of anorexia nervosa. The guidelines suggest two measures used to determine “normal” weight involving: 1) age and height weight charts or pediatric growth charts; and 2) measuring one’s body mass index in which below normal would be equal to or less than 17.5 kg/m². In addition, an individual’s weight history and body build need to be considered.

- Criterion B regards the intense fear of fatness and weight gain common to those individuals suffering from anorexia nervosa.
- Criterion C speaks to the body image disturbance experienced by those with anorexia nervosa and their distorted perception of seeing their body as fat even though they are truly thin.
- Criterion D is the diagnosis of amenorrhea or the absence of menstruation for at least three consecutive cycles.

Because of this last criterion, men can never meet the full diagnostic measure of having anorexia nervosa even when all of the other criteria are present.

In addition to the criteria, two types are identified: (a) Restricting in which the individual restricts food intake without purging or binge-eating behavior; and (b) Binge-Eating/Purging in which the individual regularly self-induces vomiting or misuses enemas, laxatives, and/or diuretics.

Bulimia Nervosa (BN). Individuals with bulimia nervosa tend to eat great quantities of food in one sitting and engage in compensatory actions to reduce the

potential for weight gain. Five criteria as published in the DSM-IV-TR (APA, 2000) must be met for a bulimia nervosa diagnosis. These criteria include:

- “Recurrent episodes of binge eating” (APA, 2000, p. 594). An episode involves both eating within a distinct period of time (usually less than 2 hours) an amount of food clearly greater than the average person would consume during a similar time period and under similar conditions and a sense of having no control over one’s behavior in the moment.
- Recurrent use of negative behaviors, such as self-induced vomiting, excessive exercising, and or misusing aperients, in an attempt to avoid gaining weight.
- “The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months” (APA, 2000, p. 594).
- The individual’s internalized body concept comes across as having an excessive emphasis on body shape and weight.
- This illness does not present solely during anorexia nervosa episodes.

In addition to the above-listed criteria, the DSM-IV-TR (APA, 2000) identifies two subtypes to better identify purging behaviors: (a) Purging Type in which the individual regularly engages in negative compensatory behaviors; and (b) Nonpurging Type in which the individual does not regularly engage in self-induced vomiting or aperient misuse, but has used other inappropriate methods like abstaining from all or some foods and drink and/or excessive exercise.

Eating Disorder Not Otherwise Specified (EDNOS). “This diagnosis includes disorders of eating that do not meet the criteria for Anorexia Nervosa or Bulimia

Nervosa” (APA, 2000, p. 594). Individuals that fall under this category suffer from behaviors that resemble AN or BN, but do not meet the criteria. For example, an individual can meet all of the criteria for AN, except they have a regular menses, are postmenopausal, or male. The statistics are not clear, but most research indicates that one-third of all eating disorder diagnosis fall under the EDNOS category (Costin, 2007). Patients in critical need will not gain access to residential care because they do not meet the specific criteria for AN or BN, which is a prerequisite for this higher level of treatment. Drummond’s (2002) qualitative study shared a participant’s story of worsening his illness so that he could be admitted into residential care.

Binge Eating Disorder (BED). BED is uncontrolled binge eating without vomiting or laxative abuse. BED is often, but not always, associated with obesity symptoms.

Night Eating Syndrome. Individuals eat at night without awareness. The eating pattern is exhibiting morning anorexia with an increased appetite in the evening as well as insomnia. These patients can have complete or partial amnesia for eating during the night.

Reverse Anorexia (also termed the Adonis complex). Prevalent among males defined as the fear of being too small or weak (Pope, Phillips, & Olivardia, 2000). Men become obsessed with building muscle.

Problem Statement

Men are presenting in therapeutic settings (e.g., hospital, day treatment, private practice), with eating disorders, but there is very little research about men with eating disorders. Since eating disorders have been stereotyped as a female problem, men are

hesitant to seek treatment and/or are not diagnosed with having an eating disorder. Men that do seek treatment encounter situations designed to address females; for example, eating disorder inventories that ask questions about menses and group environments in which all of the participants are female. This dissertation research is designed to learn more about how men experience having an eating disorder from etiology to recovery.

Purpose of the Study

The purpose of this phenomenological study was to understand how men make meaning of their eating disorders from etiology to recovery. The eating disorder phenomenon is generally defined as “severe disturbances in eating behavior” (APA, 2000). Eating disorders are “complex conditions that arise from a variety of factors, including physical, psychological, interpersonal, and social issues” (Eating Disorders Awareness and Prevention, 1999). The current diagnostic classification text (DSM-IV-TR, APA, 2000) identifies two specific diagnoses, anorexia nervosa (AN) and bulimia nervosa (BN). Other eating disorders that do not meet the criteria for AN or BN are coded as eating disorder not otherwise specified (EDNOS); for example, binge eating disorder (BED) is identified as a condition requiring further study in the DSM-IV-TR (APA, 2000) and therefore, would be coded as EDNOS (Williamson, Martin, & Stewart, 2004). The objectives of this dissertation study include:

- To raise awareness that eating disorders and eating disordered behaviors are non-discriminate. This research could help impress upon the medical community and mental health professionals to move away from stereotypical thinking about eating disorders; for instance, recognizing that in addition to the 24 million people of all ages and genders diagnosed with AN, BN,

EDNOS, and BED, 10-15% are males (ANAD, n.d., Eating Disorders Statistics), and perhaps more, as men are less likely to seek treatment. Men have been under-diagnosed and underreported (Strother et al., 2012) as eating disorders has not been fully acknowledged and deemed “atypical” for this population.

- To learn how men experience treatment that is primarily focused on women with an eating disorder. For example, there is some debate as to whether eating disorder clients should be in mixed groups or heterogeneous groups (Costin, 2007). A recommendation for separating group therapy according to gender may prove to be a necessity for males to recover from an eating disorder.
- To discover the challenges men face in living with an eating disorder. In order to recommend best treatment practices for men, additional research is needed to learn the differences between the genders; otherwise, men will continue to be misunderstood and under-diagnosed as well as the probability of negative treatment outcomes (Andersen, 1990; Andersen et al., 2000; Strother et al., 2012). While symptomology of the eating disorders is similar (e.g., anorexics demonstrate purposeful restriction of food and bulimics report bingeing and purging), Norris, et al., 2012), an awareness of issues specific to men (masculinity, higher competitiveness, importance placed on body shape versus body weight) is needed (Andersen, 1990; Andersen et al., 2000; Drummond, 2002; Strother et al., 2012).

- To recognize and better understand the recovery process for males with eating disorders.

Research Questions

This dissertation research can contribute, in several ways, to the literature on how men experience eating disorders. First, by adding more information about how men are affected by social media's portrayal of beauty and the ideal male body. Second, this study may help provide validation to men, in realizing they are not alone with their struggles with eating behaviors and recognizing other men experiencing similar attitudes and behaviors. Third, this study may be able to determine if eating disorder treatments established for women also benefit men. Fourth, this study offers greater insight into how men make meaning of having an eating disorder. Fifth, the literature about men with eating disorders is sparse; hence, the need for this research is great.

The central question this research study addressed is how men make meaning of their eating disorder from etiology to recovery. Several sub-questions assisted the researcher in addressing this question. These were:

- What was the etiology of each participant's eating disorder?
- What prompted participants to get treatment?
- What is each participant's experience of having sought and undergone treatment in a heterogeneous or homogeneous environment?
- How were participants' perspectives altered through treatment?
- What interventions inspired participants to shift their perspectives regarding eating disorder behaviors?

Limitations

There were limitations to this study, including generalizability of the findings from these volunteer participants to the larger population. An additional limitation was the lack of such comparable resources, which further explain eating disorders from the perspective of the male clientele.

Summary

This dissertation research advances the search for finding a healing treatment for men with eating disorders. The intention of this dissertation study was to provide insight into each participant's experience as a means to help clinicians recognize the function an eating disorder has on identity, sense of control, and quality of life. This study adds to the literature, a deeper understanding into the causes and perpetuations of participants' eating disordered behaviors in asking each to respond to questions addressing how they, men, make meaning of having an eating disorder.

CHAPTER II

LITERATURE REVIEW

Chapter II summarizes the literature on eating disorders, especially as it pertains to men, as well as qualitative studies, which depict how individuals make personal meaning in having an eating disorder. This literature review helps inform this dissertation research and methodology.

Introduction

Are eating disorders “a side effect of consumer culture” (Rohlinger, 2002, p.70)? Current cultural values place a high priority on physical appearance; it is not surprising that over 50% of Americans are on a diet during the course of a year in an effort to maintain or lose weight. Dieting behaviors and other actions taken toward reshaping one’s figure can quickly spin out of control, developing into an eating disorder (NEDA, 2010; Valois et al., 2003). Individuals with a proclivity toward anxiety, depression, obsessive-compulsive disorder or a family history of eating disorders are especially at risk. According to NEDA (2010), more than one in three dieters progress to pathological dieting. These extreme behaviors may not be recognized as pathological, since the obsession over weight and dieting is so ingrained in American culture as a normative behavior (Haworth-Hoepfner, 2000; Moulding, 2007; Tiggemann & Slater, 2004). Of

course, one may acquire an eating disorder for reasons separate from socio-cultural influence. Other factors, like childhood verbal, physical and/or sexual abuse, not highlighted as broadly as the influence of socio-cultural factors, explains how some individuals experiencing intense emotional pain cope by controlling something in their lives (Polivy & Herman, 2002); for example, restrictive eating habits can offer a false sense of control. These behaviors may be deemed as one conforming to a dieting standard, while in fact, they have to do with factors like biological, developmental, and/or environmental contributors.

Eating Disorders and Gender Issues

Most of the literature contends that eating disorders (ED) are primarily a female issue (Andersen, 1990), however, one of the first reported cases in 1689 was a boy approximately 16 years of age who presented with anorexia nervosa (Silverman, 1990). Seventy-five years later, another report of a 14-year-old boy with anorexia was detailed by Whytt of Edinburgh. In 1790, Willan produced the story of a young man who abstained from food for religious purposes for 78 days before death overcame him (Silverman, 1990). While most autobiographies and published accounts of eating disorders are authored by females, several men have shared their narratives, too.

The occurrence of eating disorders is not unfounded among the male population. Recent studies suggest that not only do men present with eating pathology, but that the numbers are on the rise. For years, the statistics indicated that only one in ten patients diagnosed with an eating disorder is a male (Andersen, 1990); but current research suggests higher and increasing rates of men are diagnosed with an eating disorder (Bunnell, 2010). For instance, Hudson et al. (2007) “found a surprisingly high proportion

of men with anorexia nervosa and bulimia nervosa (representing approximately one-fourth of cases of each of these disorders)” (p. 352).

Tantleff-Dunn, Barnes, and Larose (2011) completed a survey of 472 participants, of which 135 were men, to assess if body image dissatisfaction is stereotypical of women or if men experience similar feelings. Participants reported that body image disturbance was normative and stereotypical for both genders; however, men favored a muscular form rather than the thin ideal women endorsed. This trend of increased body dissatisfaction among males may indicate individuals manifesting negative body image schema. This is cause for concern, as empirical evidence found that body image disturbances are precursors for eating disorders (Polivy & Herman, 2002). The rise in body image dissatisfaction among the male population suggests that men are at risk for developing an eating disorder; even though the trend seems to indicate men experience normative discontent with their figures, they continue to be underdiagnosed and undertreated for eating disorders (Andersen, 1999; Strother et al., 2012).

Weltzin et al. (2012) concurred with other studies that women are diagnosed more frequently with AN and BN, but men do present with eating pathology and frequency rates are increasing. In another study, researchers reported small to moderate differences in the presentation of eating disorder behaviors between the genders, with one of those differences being that men tend to engage in binge eating and excessive exercise to maintain a desired weight (Striegel-Moore et al., 2009). Hudson et al. (2007) reported 28% of male adolescents engaged in disordered eating habits including fasting, skipping meals, using diet pills, purging, and/or using laxatives for weight control. In summarizing their findings, Weltzin et al. (2012) stated, “We anticipate a continued significant number

of males will be affected by eating disorders. Our observation is this population is growing” (p. 457).

The incidence and prevalence is intensifying as evidenced by the currently published data on the National Eating Disorders Association website. The NEDA states “in the United States, 20 million women and 10 million men suffer from a clinically significant eating disorder at some time in their life, including anorexia nervosa, bulimia nervosa, binge eating disorder, or an eating disorder not otherwise specified” (NEDA, n.d., “Get the Facts on Eating Disorders,” para. 2). While there is much research confirming the high incidence rates among adolescent girls (Bunnell, 2010; Costin, 2007; Hoek & van Hoeken, 2003; Maine & Bunnell, 2008; Soban, 2006), there is now evidence of the increased number of boys presenting with an eating disorder. Bayes and Madden (2011) recently published findings of male patients between the ages of 10 and 13 years being treated for anorexia nervosa in children’s hospitals. The primary compensatory behavior reported was excessive exercising, and even though all were in a critical medical state, half of the patients did not meet the weight criteria for AN diagnosis. The main concerns reported by these patients were that they were not muscular enough or were too fat.

Studies have demonstrated the experiential differences between the genders. For example, men may develop an eating disorder if they were overweight or obese during childhood, while women usually were at a normal weight but still felt fat and engaged in dieting behaviors (Strother et al., 2012). Strother et al.’s (2012) study also restated the relationship between sexual abuse and body image disturbances. Men are less likely to

report sexual abuse, again, due to a fear of being associated with a female stereotype, or due to the shame and stigma attached to such a traumatic event.

Eating disorder behaviors may serve as a solution to avoiding sexual issues all together (Morgan, 2008; Strother et al., 2012). A lower body weight, such as that maintained by someone with anorexia, will lower testosterone levels resulting in a low or nonexistent sex drive.

Depression and shame are traits often experienced by individuals suffering from an eating disorder. Most men, however, will react through violence or anger rather than appearing feminine (Strother et al., 2012). They may use other coping strategies more culturally accepted and expected for males, such as using alcohol and/or other substances to distract from body disturbances. While both genders will engage in excessive exercise, muscle dysmorphia and the use of steroids appears to be more specific to men (Strother et al., 2012). Similar to women, men experience a sense of body dissatisfaction following media presentations that show muscular males as an ideal body type (Agliata & Tantleff-Dunn, 2004; Barlett et al., 2008). While the body image concerns differ between the genders, the drive to attain the media's ideal body seems to promote eating disorder behaviors for both men and women (Strother et al., 2012).

The evidence suggesting a rise in body image disturbances among males, increased reports of heterosexual boys and men not involved in media- or sports-related positions diagnosed with eating disorders, and the under-diagnosis/misdiagnosis of men with eating disorders reiterates the importance of doing research that will bring attention to the fact that eating disorders are pervasive, affecting both women and men. Because eating disorders are typically associated with female issues, clinicians do not look for

eating disorder as a possible diagnosis for men. Furthermore, men that are diagnosed require treatment that will focus on unique issues related to the masculine ideal.

This review of the literature continues with a summary of studies that have contributed to our understanding of how men present with an eating disorder.

Eating Disorder Risk Factors

There are several risk factors or variables reliably associated with eating disordered behaviors. The media is the most identified factor in triggering body dissatisfaction in media consumers (Haworth-Hoepfner, 2000; Levine & Murnen, 2009). It has been established that mass media messages, replete with positive attributes associated with being thin and the negative features corresponding to being overweight, directly affect media consumers' body image contentment and self-esteem. Moreover, research has demonstrated that there is a link between body dissatisfaction and eating disordered behaviors (Peterson et al., 2007).

Media influence is reported to be higher for gay men suggesting greater vulnerability for eating pathology to develop in this population (Carper, Negy, & Tantleff-Dunn, 2010). Norris, et al. (2012) examined the clinical profile of males with eating disorders. Of 52 adolescent males (mean age 14.7) participating in their study, 26 (50%) identified as being heterosexual, 20 (38.5%) did not report, 3 (6%) reported being homosexual, 2 (4%) bisexual, and 1 (2%) asexual. "Our finding that 16% of those asked about sexual orientation identified as either homosexual or bisexual supports the observation demonstrated in previously published studies that gender and sexuality-specific stressors may elevate risk in a sub-set of patients" (p. 411).

While the reported statistics seem to indicate a greater prevalence for eating disorders in the gay community, other studies indicate that most males with an eating disorder are heterosexual (Carlat, Camargo & Herzog, 1997; Feldman & Meyer, 2007). Carlat et al. (1997) reported on 135 patients with a mean age of 19.3 years, in comparison to Norris et al. (2012) survey of 52 adolescent males with a mean age of 14.7 years, a limitation noted in the latter studies' conclusions. "The majority of men do not describe themselves as homosexual" (de Beer & Wren, 2012, p. 435), but it is generally recognized that gay men are at a higher risk for developing an eating disorder. Men associating their illness with having a "female disease" may exhibit gender and or sexual identity confusion, which may be further exacerbated by a low libido due to low testosterone levels. For instance, "they may have interpreted their lack of interest in heterosexual sex as evidence of being gay" (de Beer & Wren, 2012, p. 435). Furthermore, men are hesitant to seek treatment due to the fear that they will not appear masculine (Soban, 2006), so the actual number of men with an eating disorder is not truly known; hence, comparisons among men may be inflated.

While the media influence has been highlighted as a major factor in the onset of eating disorders, there are other risk factors that have an equal probability in triggering an eating disorder (Levine & Murnen, 2009). Other influences include peer pressure, family influence, a family history of weight concerns, and a belief that one's worth is based on appearance. The media, peer pressure and family roles have each been researched and found to have influence in increasing one's sense of body image dissatisfaction, but any one of these factors alone is not enough to explain the onset of an eating disorder (AED, 2010; Haworth-Hoepfner, 2000; Polivy & Herman, 2002). Haworth-Hoepfner (2000)

cited critics that have clearly argued “that culture is not a unitary force behind action nor is it independent from the interaction of actors” (p. 214). It is only through human interaction in which the ideal figure becomes relevant. Still, few articles have examined how all the various factors work together to compound the problem. Furthermore, very few studies have focused on men. There is very little, if any, evidence of the response to diagnosis and treatment measures among the male population. Men are less likely to be asked about their eating and exercise habits or assessed for an eating disorder unless the men seek help specifically related to a problem with disordered eating (Strother et al., 2012).

Clinical Features

Males and females, reportedly, share similar signs and symptoms. While eating disorders may present at any age, it is believed that onset typically begins during the developmental transition into adolescence (Andersen, 1990; Bunnell, 2010; Freeman, 2005). There are few differences between males and females in comorbidity rates (Woodside et al, 2001) and in personality traits common to those individuals with an eating disorder, such as perfectionistic and obsessive-compulsive tendencies, low self-esteem, and poor interoceptive awareness (Bunnell, 2010). Both males and females appear to have a pre-occupation with their weight and a high level of body dissatisfaction (Crisp & Burns, 1990). Norris et al. (2012) stated “it has been shown that the manner in which males and females present at the time of eating disorder assessment is relatively similar” (p. 411). While there are similarities, there are notable differences as well.

Societal standards have a higher acceptance for men that overeat, so it is more difficult to assess a binge episode from overeating. Additionally, men tend to use exercise

to purge rather than induce vomiting. Exercise is seen as a normative feature for men, so again, assessing what is within the range of healthy exercise and excessive exercise can be complicated. Weight measurements used to diagnose AN may be inadequate in assessing the disorder severity in males due to higher muscle mass. Andersen (1990) explained that girls have a tendency to carry fat “on” them while boys carry fat “in” them. Women store fat in different places like on the hips, buttocks and thighs developing subcutaneous fat. Men gain weight in their upper body, usually around the abdominal region; hence, men may acquire “beer bellies.” Culturally, women endorse a thin physique while men strive for a lean, muscular appearance. Women with eating disorders often have a “magic number” representing their perception of the ideal weight. Men tend to focus more on shape and, generally, do not have specific weight goals (Bunnell, 2010; Freeman, 2005). This plays an important role in recovery as males usually regain weight without the same over concern women with eating disorders seem to exhibit.

Both genders suffer from medical concerns; the medical complications associated with malnutrition, purging, and over-exercising are many including conditions affecting the skin, the heart and other central organs, and dentition (Glover & Sharma, 2012). Men are at risk for impairing endocrine functioning; low testosterone levels can increase the risk for osteopenia and osteoporosis, irreversible conditions. Testosterone levels are restored and the sex drive returned once weight measures within a healthy range; while women may experience the return of their menstruation cycle, their sex drive may continue to be lower than expected norms.

Research exploring the relationship between eating disorders and anger has demonstrated differences between genders. Peñas-Lledó et al. (2004) reported males and

females exhibit different behaviors when expressing anger. “External expression of anger was related to binge-eating regardless of gender, but was associated with different facets of impulsivity for males and females” (p. 395). Men engaged in impulsive behaviors including substance/alcohol use and other self-harming behaviors, while women demonstrated increased bingeing and purging in expressing their anger. The findings tend to suggest bulimic behaviors are associated with suppressed anger in women, but state anger in men. In other words, “men engage in bulimic behaviors as an immediate response to anger” (Meyer et al., 2005, p. 70).

Research also indicates a high comorbidity of eating disorders and addictive behaviors, such as alcohol and/or substance abuse. Strother et al. (2012) indicated a high co-morbidity rate among eating disorder patients with substance abuse and indicated men appeared to struggle at almost twice the rate as women. Stimulants are often used to control weight; men are known to abuse steroids of which the side effects include depression and suicidal ideation. “A distinct disadvantage of males’ obsession with physical fitness is the epidemic use of anabolic steroids to build muscle mass and boost strength” (Andersen, 1990, p. 32). A behavior initiated to assist in achieving an ideal body image may result in harmful physiological changes, negative affect, and addiction potential.

Competition is a main feature of masculinity and eating disordered men tend to project this trait in treatment as well as in competing with self. “Sometimes, I think this whole anorexia issue started as a game ten years ago and just got out of hand” (Krasnow, 1996, p. 82); “one of the men had a driving goal to be the sickest male in the eating disorders unit” (Drummond, 2002, “Eating Disorders as a Form of Competition,” para.

2); “I’d like to see one of these pretty people run five miles, bike thirty miles, swim twenty-five Olympic-pool-sized laps, and then lift weights – all without putting any food in their stomach before three in the afternoon” (Saxen, 2007, p. 6). Similar to women measuring personal self-worth based on a cultural definition of beauty and a thin ideal (Hesse-Biber et al, 2006), men are measuring their masculinity based on a muscular built (Drummond, 2002).

Body dissatisfaction materializes when an individual perceives a mismatch between ideal male body types and one’s body. This may be furthered exploited if an individual has been teased and/or bullied for perceived reasons directly related to physical appearance. In the treatment of male eating disordered clients, Bunnell (2011), Andersen (1990), Costin (2007), and Wilps (1990) reported a shared occurrence in that many of their clients disclosed having a history of being teased and/or bullied, leaving them feeling shamed and humiliated.

Incorporating cultural attitudes is one influence in constructing a body schema; body esteem incorporates the physical attributes of the body as well as one’s attitude, emotion and temperament toward their body (Kearney-Cooke & Steichen-Asch, 1990). “Disturbance of body image is a multidimensional phenomenon, including such issues as distortion of body size, dissatisfaction with body size, concern with body shape, and insensitivity to introceptive cues” (Kearney-Cooke & Steichen-Asch, 1990, p. 55). Individuals establish attitudes through their interactions with the environment. A healthy state of congruence is experienced when one’s perceived reality matches one’s ideal reality; in other words, how a person actually sees self and how they would like to see self-match. When there is a discrepancy, a poor body image and unfavorable body

schemas result in having an overall negative impact on self-esteem and putting an individual at risk for developing an eating disorder (Carper et al., 2010).

Biological Factors

In addition to the media and socio-cultural messages that can trigger eating disorder behaviors, other biological predispositions may also be at work. Freud (2007) identified six domains regarding the relationship between Obsessive-Compulsive Disorder and Eating disorders: (a) importance of thoughts; (b) control of thoughts; (c) responsibility; (d) overestimation of threat; (e) intolerance of uncertainty; and (f) perfectionism. Studies indicated that the onset of obsessive compulsive and perfectionistic tendencies precede eating disorder behaviors (Finzi-Dottan & Zubery, 2009). Finzi-Dottan and Zubery's (2009) findings "strengthen the assumption" that eating disorder behaviors are "regulation mechanisms" (p. 176). In concert with other studies, Finzi-Dottan and Zubery (2009) found that those diagnosed with bulimia nervosa exhibited impulsivity and used the disorder to manage negative mood while anorexic patients were preoccupied with being in control, as demonstrated by their willfulness in restricting food intake.

Additionally, mental health practitioners and researchers have recognized that individuals with certain personality traits, such as obsessive compulsiveness, a perfectionistic orientation, and/or an inability to regulate emotions, tend to have a proclivity toward an eating disorder (APA, 2000, pp. 585-586). Hence, recent studies are uncovering the heritability factors and suggest that there may be a relationship between environmental factors and genetics (Peterson et al., 2007). The question still remains

whether impulsivity and/or obsessive-compulsive characteristics are predictors of an eating disorder or if these are comorbid characteristics.

The study conducted by Rørtveit, Åström, and Severinsson (2009) raised awareness of the connection between shame and one's eating disorder behaviors as well as the intensity of bodily sensations during the refeeding process. Their findings are consistent with reasons many treatments fail (NICE, 2004; Seidinger, Garcia, Böttcher-Luiz, & Turato, 2011). Patients can struggle with an unwanted self and the eating disorder serves as a coping mechanism (Fox, Larkin, & Leung, 2011). This unwanted self may develop out of a sense of shame, often expressed in critical self-talk such as "I'm not worthy," "I'm disgusting," "I'm inadequate" (Rørtveit, Åström, & Severinsson, 2009; Shure, 2012; Strother et al., 2012). In addition to Rørtveit et al.'s (2009) research, other studies indicated "the persistence of characteristic abnormalities in eating behavior sets the stage for the perpetuation of this serious illness" (Walsh, 2011, p. 529).

Personal Narratives

After reviewing the literature for eating disorder risk factors including clinical features and biological factors, this reviewer was interested in learning more of personal experiences of men with eating disorders. Following are brief passages from autobiographies of three men that have struggled with an eating disorder. The passages chosen depict the negative self-concept expressed by each, which contributed to the formation of the eating disorder.

Michael Krasnow. Michael Krasnow wrote his story with the intention to help men "come forward without worrying about embarrassment" (Krasnow, 1996, p. 1). Michael Krasnow, a severe anorexic wrote in his memoir (1996), "It was at the start of

my first year in high school, September 1983 that my “fat feelings” gained strength, and my troubles started” (p. 9). According to the Broward-Palm Beach New Times report, he died October 9, 1997, at age 28 years. He was five-foot-ten and weighed 64 pounds. Krasnow’s negative self-concept was evidenced by his statement, “I hated myself for being such a jerk, an idiot, a pathetic human being, and a complete waste” (p. 79).

Ralph Wilps, Jr. Ralph Wilps, Jr. (1990) did not inherit his father’s “powerful physique” (p. 11) and reported that he was bullied and teased “because of my slightness, nearsightedness, and tension” (p.12). Wilps, a mental health professional treating individuals with eating disorders, is able to share his narrative from the patient and practitioner perspective. He developed food-related patterns of behavior in response to a need to feel safe and a need to belong. He wrote, “Symbolic affiliation without real human contact and the nurtured, sleepy feeling of being very full and slightly drunk were my goals” (p. 18).

Ron Saxen. Ron Saxen struggled with binge eating disorder, which may have started due to the teasing and name-calling he endured as a child. Additionally, he reported having to endure extreme discipline measures and follow a strict religious upbringing. Saxen shared his weight fluctuations from nearing 300 pounds to his 179 pound frame appearing on the cover of *Muscle and Fitness* magazine. He shared his negative self-concept stating, “Kill the fat, ugly, wrong Ron and anoint me as perfect.”

The above examples serve to demonstrate the impact one’s inferior self-evaluation has on an individual’s overall well-being. Theoretically, it is posited that a negative self-concept may predict eating pathology and low self-esteem has been associated with poor treatment outcomes (Bardone-Cone et al, 2010), yet it does not

appear to be a focus of treatment. Qualitative studies have further supported the notion that individuals exhibiting increased self-worth and acceptance are less likely to relapse. This is reviewed further in the next section.

Qualitative Studies

There are very few qualitative studies using male participants. A doctoral thesis conducted by de Beer (2009), consisted of interviews with nine men with an AN diagnosis. They ranged in age from 21-42 years. Three themes were identified: (a) The eating disorder served to define individuals' physical identities through fitness activities; (b) The stigma of having an illness associated with women left participants feeling emasculated; and (c) "experiencing care as control" representative of the anorexic's struggle for autonomy and a mistrust in allowing caregivers to have some say in their well-being (de Beer & Wren, 2012, p. 432).

Drummond (2002) explored the relationship between eating disorders and manliness. Eight participants responded to questions relating to their perceptions of masculine identity with regard to their eating disorder. The themes that emerged were: (a) engaging in eating disorder behavior in a competitive manner including the sense of needing to win to prove success; (b) a connection with body size and fat which presented as not being able to eat fatty foods and/or not being able to tolerate body fat; and (c) a sense of emasculation or having a "flawed" identity.

One qualitative study described recovery from an eating disorder. Björk, Wallin, and Pettersen (2012) thematically described 15 male participants' recovery processes as exhibiting body acceptance and greater self-worth. The study did not share what portion

of the treatment process allowed for healing, but the men did perceive themselves as being recovered and better able to cope with impulses to either diet or exercise.

Other qualitative studies have involved female participants, but these help to inform this dissertation. The summations of these follow.

Fox, Larkin, and Leung (2011) conducted a study to explore the personal meaning and role of eating disorder symptoms in the lives of eight women. Their qualitative study identified three overarching themes: (a) experience of the eating difficulties as functional; (b) negative effects of having eating difficulties; and (c) ambivalence towards the eating difficulties. The functional eating disorder behaviors served mainly as distractions from other challenges participants did not want to deal with in their lives. The negative effects from the disorder were not great enough to warrant a change in their behaviors. Their diets gave them a sense of accomplishment and contributed to feeling safe and comfortable in their environments. While participants were able to list the many challenges having an eating disorder presented, they also felt the eating disorder served a greater purpose.

Nordbø, Espeset, Gulliksen, Skårderud, and Holte (2006) published a qualitative study, which explored the psychological meanings that individuals with anorexia nervosa attributed to their behaviors. They found eight constructs common among the 18 female participants: (a) security; (b) avoidance of negative emotions; (c) mental strength or an inner sense of mastery; (d) self-confidence; (e) identity; (f) eliciting care from others; (g) a means to communicate difficulties to other people; and (h) a wish to starve oneself to death. Per their findings, the participants reported different origins for each of these constructs. For some, the psychological meaning of their eating disorder was the trigger

for their anorexic behaviors. For others, faulty reasoning justified the anorexic behaviors and maladaptive dieting behaviors spiraled out of control. Some participants reported making psychological meaning, such as a sense of mastery, once the anorexic behaviors had become habitual; these intrinsic factors became salient and characterizations of self (e.g., invulnerable, confident).

These qualitative approaches exemplify the egosyntonic features of an eating disorder. The participants of the studies reported thoughts and behaviors consistent with their idea of self. In my own experience in treating individuals with an eating disorder, patients have reported the sense of identifying with their eating disorder, exclaiming that this is a way of being in the world. While the constructs are labeled differently, the main themes of identity, inner power, and control are consistent with the eating disorder literature. In most of these cases, the drive to be thin triggers the restrictive dieting behaviors, but the perceived rewards (e.g., loss of weight, feeling confident and strong, in control) seemingly prevent one from letting go of eating disorder behaviors.

Rørtveit et al. (2009) found two overall themes in a qualitative study of women suffering from eating disorders (ED). The first theme is a feeling of being trapped by powerful physical sensations. The authors described three subthemes related to the feeling of being trapped: experiencing physical sensations, being physically devoted to the ED, and bodily suffering as a consequence of the ED. The second theme was labeled experiencing shame or feeling of being ashamed of one's own body. Two subthemes were described as the feeling of being judged by others and hiding/lying to conceal the ED actions.

Treatment and Recovery

Given the current mental health environment where insurance agencies have regulations establishing mode (i.e., individual, group, or family), frequency, and setting (i.e., in-patient, out-patient), it has become increasingly more important to establish empirically validated treatments (Hubble et al., 1999). Yalom (2002) spoke of the paradox inherent in the notion of having to “standardize therapy:”

that is, a uniform therapy for all the subjects in the project that can in the future be replicated by other researchers and therapists... *And yet that very act of standardization renders the therapy less real and less effective.*” (p. 33)

Therapy doesn't fit in a box like that; therapy is spontaneous, dynamic, evolving. It is not something that can be read from a manual, broken down into steps, when followed in the correct order, promises the client will be fixed. “One of the true abominations spawned by the managed-care movement is the ever greater reliance on protocol therapy in which therapists are required to adhere to a prescribed sequence, a schedule of topics and exercises to be followed each week” (Yalom, 2002, 34).

Clarkson (2004) summarized the three major streams of psychology. Very briefly, the first category is psychoanalysis based on the writings of Freud and his followers. In this approach there is a heavy emphasis on making the unconscious thoughts known and realizing the functions of the ego-defense mechanisms. The second grouping follows the teachings of Pavlov (1927) and the notion that through behavior modification we can learn new behaviors and change unwanted behaviors. Behavioral (Lindsley, Skinner, & Solomon, 1953) and cognitive behavioral approaches (Beck, Rush, Shaw, & Emery, 1979) fall in this grouping and focus on the notion that if one changes their thoughts, they

can change their behavior. The third model includes the humanistic, existential theorists like Carl Rogers (1951), Abraham Maslow (1954), Victor Frankl (1946/2006), and Fritz Perls (Perls, Hefferline, & Goodman, 1951). These approaches are client-centered, stressing a balance among body, mind and spirit. Regardless of approach taken, there is no evidence to suggest that any one of these methods is the “right” or “perfect” method. Each theory has its strengths and its limitations. As a matter of fact, what research has found is that the best indicator for improvement in mental health is the client-practitioner relationship (American Psychiatric Association, 2006, as cited by McGilley & Szablewski, 2010, p. 197) accounting for “30% of the successful outcome variance” (Hubble et al., 1999, p. 9). In a national survey of 423 practicing clinicians, 68% shared that they use an eclectic approach rather than a specific theoretical orientation preferring to focus on matching the client’s personality, presenting problem, and so on (Coleman, 2004).

To date, there is no absolute or preferred treatment for eating disorders. There are treatment methods that have proven successful with bulimia nervosa and certain behaviors (i.e., purging) associated with eating disorders, however, the research and practitioners working with clients suffering from eating disorders are still seeking solutions. Overwhelmingly, in articles and texts regarding the treatment of eating disorders, there is a call for future research to find ways to effectively treat sufferers. “While directive, symptom-focused approaches have demonstrable power to help establish stability and normalization of eating, longer term recovery requires something more subjective” (Maine & Bunnell, 2010, p. 12). This dissertation research could serve in the advancement of finding a healing treatment for this population.

Maine, McGilley and Bunnell (2010), clinicians involved in the treatment of eating disorders, have written extensively on the disparity between clinical practice and published research. They and others share the concern that while the research seems to indicate that cognitive behavioral therapy (CBT) is an empirically supported best practice in the treatment of eating disorders, the reality demonstrates that the efficacy of actual treatments remain elusive (Berkman, Lohr, & Bulik, 2007; Gilbert, 2000; Keel & Brown, 2010; Lapidus, 2010; Maine et al., 2010; McGilley & Szablewski, 2010; Schaffer, 2003). Treatment and recovery from an eating disorder is complicated for several reasons. One, the symptoms are egosyntonic and therefore, individuals often exhibit intransigent, willful attitudes. Commitment and motivational issues often interfere with treatment as well as other factors such as lack of self-control; a perfectionist belief system; obsessive compulsive disorder; dichotomous thinking; an inability to self-regulate emotions; anxiety, especially around meal times; a lack of interoceptive awareness; and a high measure of body dissatisfaction (Erguner-Tekinalp & Gillespie, 2010; Strother et al., 2012; Walsh, 2011). Second, the high rate of comorbidity of other mental health disorders and an eating disorder diagnosis impedes treatment. Last, but not least, is that the treatments currently used offer short-term improvements, but less than half of the sufferers make a full and lasting recovery (Berkman et al., 2007; Cloak & Powers, 2010; Fairburn, 2008; Maine & Bunnell, 2010; Schaffer, 2003). In their review of empirical studies, Cloak and Powers (2010) found:

...only seven of 43 outcome measures in 15 trials of CBT showed that patients' post-treatment binge-purge frequency or Eating Disorder Examination (EDE) scores were equivalent to those of a normal sample

(Lundgren, Danoff-Burg & Anderson, 2004). In another analysis of 19 studies, purge abstinence rate after CBT ranged from only 35 to 55% (Richards et al., 2000). For anorexia nervosa, evidence-based treatment is essentially non-existent at this time. Other than family therapy for younger adolescents, there is little evidence to support any specific intervention for anorexia (Bulik, Berkman & Brownley, 2007); time to recovery is protracted (Strober, Freeman, & Morell, 1997) and less than half of patients are described as recovered at long-term follow-up (Steinhausen, 2002). (p. 143)

Recovery numbers are higher for those individuals diagnosed with bulimia nervosa, with more than half fully recovering following therapy. It is reported that over a 10-year period, “approximately 43% of individuals treated for anorexia nervosa recover fully, 36% improve, 20% continue to suffer and 5% die either from suicide or complications from anorexia nervosa” (National Institute for Health and Care Excellence, 2004, p. 16). Only 45-50% of patients with a BN diagnosis recover (Vanderlinden, 2008). Not all patients meet treatment with success. The challenge appears to be in individuals’ resistances to adapting more realistic and accepting beliefs about self and their bodies. In addition to a focus toward eating disorder recovery, the physical health consequences -- like osteoporosis, gastrointestinal complications, and dental problems -- carry a significant wellness and financial burden throughout one’s life (Costin, 2007; NEDA, 2010).

The National Collaborating Centre for Mental Health developed national practice guidelines for the treatment and management of diagnosed eating disorders. This report

was commissioned by NICE and is often referred to as the NICE Report (2004) in the literature. With regard to the treatment and management of anorexia nervosa, the NICE Report (2004) stated:

...overall, the body of research into the treatment of anorexia nervosa is small and inconsistent in methodological quality. The conclusions that can be drawn are limited because many studies have no follow-up data, lack the statistical power necessary to detect real effects, and use different study entry criteria and outcome measures.” (p.82)

Furthermore, there is no agreed upon approach as to the most effective therapeutic approach “either in terms of types of treatment offered, their duration, intensity or the setting in which treatment is provided” (NICE, 2004, p. 82). Of the eleven randomized controlled trials (RCTs) evaluated, the investigators concluded, “there is insufficient evidence to suggest that any particular psychological treatment (including CAT, CBT, IPT, family therapy, focal psychodynamic therapy) is superior to any other in the treatment of adult patients with anorexia nervosa either by the end of treatment or at follow-up” (NICE, 2004, p. 85).

Bulimia nervosa has been more heavily researched and studies have shown effective outcomes with CBT. However, according to the NICE Report (2004), there is insufficient evidence to determine whether CBT, CBT in combination with pharmacology treatment, or self- help treatments are more or less acceptable to patients being treated for bulimia nervosa. “Even with the best treatments currently available, up to 50 per cent of all bulimia nervosa patients may not respond adequately” (NICE Report, 2004, p. 153). The report also stated:

The nature of the psychological therapies chosen will be influenced by patient preference, their motivation, the nature of associated psychological features and their age or stage of development. Some will prefer a non-verbal projective therapy, using art, drama or music. Younger patients in particular or those who are dependent on relatives or care[give]rs are seen as often requiring family or systemic therapy. (p. 33)

The psychological component of eating disorders is often missing from “recovery.” How do individuals think about their bodies, food and eating? Bardone-Cone et al. (2010) wrote “not assessing for psychological recovery may produce a “pseudorecovery” state where individuals are “walking the walk” but internally “talking” the same eating disordered talk” (p. 195), the very behavior that predicts relapse. This raises the question as to what does “true recovery” look like? In addition to learning what recovery looks like, how do individuals make sense of their eating disorder experiences?

Theoretical approaches to treatment. This section overviews theoretical stances relevant to the treatment of eating disorders. Cognitive Behavioral Therapy (CBT), Behavioral techniques and Gestalt theory are reviewed. Particular attention is given to a Gestalt approach since it not only addresses the treatment of eating disorders, but also relates to the phenomenological methodology of this dissertation.

In articles covering systematic reviews of the research evidence, several limitations are recognized. For example, there is an inconsistency in defining outcome assessment measures (i.e., stages of illness, remission, recovery and relapse), hence, making comparisons across studies questionable (Berkman et al., 2007). Even with the acknowledgement by practitioners that the research is arguable, there does seem to be a

general consensus that CBT is the favored and seemingly most promising approach. Schaffer (2003) conveyed behavioral techniques have shown some success in establishing stable eating patterns and cognitive approaches have helped some patients in reducing dichotomous thinking and irrational beliefs. Overall, cognitive behavioral therapy is regarded as the preferred treatment measure.

The adaptability of CBT to treatment of eating disorders is partly driven by the call for evidence-based treatments and a misguided perception that the technique is the cure. Patients that meet target goals for weight but have not made cognitive shifts will most likely relapse (Noordenbos, 2011). Hubble et al. (1999) demonstrated that only 15% of treatment outcomes are associated with techniques, while 30% are directly related to therapeutic alliance and 45% to client variables. Considering the eating disorder individual, “a good therapeutic alliance is a ‘condition *sine qua non*’ before any therapeutic progress can be achieved” (Vanderlinden, 2008, p. 330). Further criticism in using a cognitive behavioral model revolves around the problem of bringing too much attention to the content, exacerbating rumination and obsessive thinking about one’s pathology (Cooper, 2012; Vanderlinden, 2008). While behavioral approaches are helpful in addressing automatic eating habits, methods that will increase self-esteem, self-acceptance, and new ways of being in relationship with one’s environment would best promote full recovery from an eating disorder. As Yontef (2007) explained, “fundamental change results from self-acceptance and not attempts to change based on self-rejection” (p. 17).

Gestalt approach. Gestalt theory is an existential, humanistic psychotherapeutic approach to mental well-being. A Gestalt approach is holistic, raising awareness of the

physical, emotional, spiritual and relational processes appropriate to the context and content being explored. It holds that the person is not just in the environment, but of the environment, and thus does not focus on “fixing” an individual, but rather understanding the complex interplay of forces of the presenting scenario (Spoth, Toman, Leichtman & Allan, 2013). The principles of Gestalt theory are primarily based in addressing the individual as a “functional, organismic whole that strives towards higher levels of potentiality, actualization, and integration within and as part of its organism/environment field” (Kirchner, 2000, para. 3).

Within that environmental field, is the ground from which every experience or figure arises. In Gestalt terms, this is referred to as the figure/ground paradigm. What becomes “figure” are those experiences or sensations salient to that individual. For the anorexic client, what has become “figure” is the drive to be thin. Changing patterns in one’s needs, will formulate new “figures.” These shifts from one “figure” to the next may occur in a matter of seconds (i.e., the sudden “aha” experience) or over a long period of time (i.e., changing behavior). Using the Cycle of Experience, the shifts between figure and ground can be described and noticed; through this process one gains an awareness into their “fixed Gestalt” or unfinished business. A person suffering from an eating disorder may be getting stuck at the awareness stage, misinterpreting the sensation of hunger for emotional neediness. By means of a Gestalt approach, the therapist would help the client raise their awareness of the interrupted energy so that the client could complete the cycle of experience (the time this takes is determined by the client).

According to Gestalt theory, “change does not take place by trying coercion, or persuasion, or by insight, interpretation, or any other such means. Rather, change can

occur when the [client] abandons, at least for the moment, what he would like to become and attempts to be what he is” (Beisser, 1970, p. 77). In other words, the potential for change occurs when individuals accept who they are. As Yontef (2007) clearly stated, “people do not change by trying to be who they are not” (p. 17). In general, people learn what works and what doesn’t work from experiences in which their thoughts and behaviors change accordingly. Using the Gestalt model, the counselor enables the client to access a wider range of choices and actualizing their potential through: (a) phenomenological focusing and experimentation to increase awareness, and (b) a relationship based on dialogic contact (Allan & Whybrow, 2007; Yontef, 2007), basically characterized by dialogue (Clarkson, 2004). Through this process, a greater awareness is realized and a deeper sense of self-respect is experienced as a practitioner who understands the client and treats him or her with unconditional regard guides the individual.

Reich (1972) introduced the notion that our bodies have memory; he stated that we store emotional memories and defenses in our muscles and internal organs. Gestalt approaches integrate this idea by focusing attention on the “‘sensing body’ as a major route to psychological integration and a release of free energy” (Clarkson, 2004, p. 12). Gestalt theory acknowledges that choices are not either/or, but, instead, flowing on a continuum between extremes (i.e., open-minded or closed-minded). While it is the tendency for individuals to lean more heavily toward one end of the continuum, the possibility of experiencing choices on the continuum is what Perls deemed “the achievement of a lovely neutrality in which an individual no longer feels pulled toward one extreme or the other and is no longer the prisoner of one way of seeing the world”

(Stevenson, 2010, p. 113). For the eating disorder client, at one end of the continuum is the need to maintain a very low body weight and at the other end is to be healthy.

Cognitive-based therapies address left-hemispheric (LH) rational, logical, analytical cognitions, while Gestalt psychology focuses on right-hemispheric (RH), non-linear, affective intelligence. Lapidés (2010) explained:

RH subliminal activation of the thoughts and affect underlying disordered eating implies the need for deeply relational and intersubjective therapeutic approaches, with an emphasis on RH resonance, rather than an exclusive reliance on LH cognitively constructed analysis and verbal interpretations (Waller & Barter, 2005). Thus, the goal of psychotherapy should be to enhance the ability for affect-regulation in our ED patients with approaches that activate the RH. (p. 44)

The practitioner can choose to introduce a Gestalt experiment (intervention) designed to aid the client in experiencing an alternative viewpoint through enactment in the here and now. As Stevenson (2005) stated, experiment “leads to an awareness of what might be, or how things could be better in the future” (p. 39). Awareness is the primary principle for change. “Awareness of and responsibility for the total field, for the self as well as the other, these give meaning and pattern to the individual’s life” (Perls, 1976, as cited by Clarkson, 2004, p. 14). “With this assumption of awareness and responsibility, increased response-ability becomes possible” (Clarkson, 2004, p. 15). For clients, the more fully aware they become about who they are and how they are being in the present, the greater their willingness to change will become evident. For the Gestalt mental health professional, validating a client’s contact style changes resistance into assistance. As

explained by Mauer (2005) in applying Gestalt principles with organizations, “we see resistance as ‘the energy,’ not the ‘enemy’ ... resistance is a creative adjustment to a situation” (p. 252).

Gestalt testimonial. Kappeler (2004) related her personal experience with using Gestalt therapy to overcome her eating disorder and alcohol abuse:

Gestalt therapy makes meaningful and orderly change possible by siding with the client’s resistance and working within the framework of the client’s experiences and beliefs. This was certainly true as I began recovering from alcoholism and bulimia: As I became aware of the structure and function of my drinking (or binging), my behavior began to change immediately. (para. 13)

She also wrote:

In my case, at the beginning of treatment, I did not have any alternatives that I knew and trusted would work. A traditional-style coercive attempt to teach new coping and living skills failed utterly. In contrast, the Gestalt approach helped me to become aware of my self-defeating patterns and to start to take responsibility for my actions and choices. (para. 16)

Gestalt approach summary. Gestalt-trained professionals uncritically accept their duty to help their clients gain a heightened sense of awareness in order to have access to a broader range of possibilities refraining from analyzing or interpreting the client’s behavior. The focus remains on the client’s contact or breaking contact with living in the moment and taking responsibility for actions made in the moment.

Kappeler’s (2004) experience left her feeling that:

Where "analysis" of behavior often inspires shame, confusion, and self-pity--and thus continues or even reinforces the rationale for misusing food or alcohol--an emphasis on the "here and now" enhances concrete understanding of the immediate consequences of this maladaptive behavior. (para. 19)

The Gestalt model aims to explore and create an awareness of fixed patterns and beliefs that individuals have about themselves which get in the way of living a healthy, productive life, whatever that is for each individual. Gestalt therapists often create experiments designed to help clients increase awareness and explore ways to solve the situation or find new coping strategies. Working in the here and now, therapists may share impressions about what is occurring in the present moment by paying attention to what happens in the moment between therapist and client, for instance, noticing nonverbal communications the client uses (i.e., gestures, body movements), or "trying it on" disclosing one's own somatic response to the client (i.e., "my chest is feeling heavy as I listen to you"). In this way, the Gestalt therapist is modeling "paying attention," what modern approaches are deeming "mindfulness," stressing the value of being in the present, bringing the client's full awareness to bear on his/her experience. "Practice of the awareness continuum... [is] an attempt to concentrate without judgment or labelling on every new figure which becomes of interest without preconception or expectation" (Clarkson, 2004, p. 92). In comparing this strategy to the mindfulness explosion currently spreading in therapeutic practices, Joyce and Sills (2010) exclaimed, "we are pleased that what has been central to Gestalt for over fifty years is now being valued by other approaches" (p. 32).

Simon (2009) suggested that “it is Gestalt theory’s focus on awareness that may differentiate it from other approaches” and that “the Gestalt practitioner understands that there is a direct relationship between the degree of awareness and the potential for new choices of behavior” (p. 237). The Paradoxical Theory of Change (Beisser, 1970) is paradoxical because in order to change one has to give up trying to change, but instead, cultivate greater awareness and a natural process of growth and change will occur. “It is trust in the healthiness of organismic self-regulation and in the deeper wisdom that lies within us all. Most of all, it is trust that if we as counselors provide the proper conditions in the process of the therapy, the client will choose his own right direction” (Joyce & Sills, 2010, p. 40).

Summary

This research is intended to discover etiology, treatment, and recovery influences. Up to this point, etiology factors and treatment modalities have been discussed. A uniform set of criteria for full recovery was not found by this researcher; however, there is consistent reporting on several factors necessary for recovery beyond getting patients to a healthy weight. These include improved interpersonal relations, higher self-esteem, a new and compassionate acceptance of self, the use of other healthier coping strategies to negotiate negative emotions, and better problem solving ability (Noordenbos, 2011; Pettersen & Rosenvinge, 2002).

Several factors have been identified as contributing to eating pathology. Furthermore, self-concept disturbances have been found to be associated with the etiology of an eating disorder and more importantly, a relationship between improved self-esteem and recovery established. Individuals’ beliefs about self and about self in

relation to others and their environment will support findings into the essence of one's experience with having an eating disorder. Using the phenomenological qualitative method; Gestalt theory, a phenomenological approach; and self-schema model, the etiology, treatment and recovery/maintenance of an eating disorder as experienced by men will be explored. The next chapter describes the methodology used to address the research questions of this dissertation.

CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

“We know not through our intellect but through our experience.”

~ Maurice Merleau-Ponty

Introduction

Eating disorders have become known as a “female issue” and where men are concerned, a “gay issue.” However, current research is raising awareness that men, outside of the stereotypical populations, are experiencing low body dissatisfaction, body image concerns, and a drive in achieving an “ideal body.” Today, men are at a higher risk for developing an eating disorder (Bayes & Madden, 2011; Tantleff-Dunn et al., 2011). Prevalence and incidence data suggest that the number of reported male eating disorder cases has increased substantially.

There has been very little research about men with an eating disorder. While current statistics have indicated females are diagnosed with an eating disorder at a higher rate than men (ANAD, n.d.; Costin, 2007), there is evidence suggesting that men are often misdiagnosed due to the increased attention this disease has given to women (Andersen, 1990; Andersen et al., 2000; Strother et al., 2012). There is strong evidence to indicate high incidents of reported eating disorders among the male population outside of

those participating in athletic sports, a career in the fashion or entertainment industry, and sexual orientation (Anderson, 1990). Increased research efforts could help create an awareness of the men and eating disorders, better inform the public and practitioners, and support individuals in overcoming their reluctance to seek treatment. The notable imbalance in the literature of eating disorder research and diagnoses of men prompted this examination into the male experience with eating disorders.

Purpose and Research Questions

It could be theorized that a valid and reproducible set of constructs expressing how eating disorder patients experience their behaviors will inform medical and mental health professionals in the treatment of men with eating disorders. For the purposes of this dissertation research, the method for discovering these constructs was based in a phenomenological approach.

The central research question for this study was “how do men make meaning of their eating disorders from etiology to recovery?” The aim of this study was to systematically explore how men with an eating disorder make meaning of their experiences. “As we research the possible meaning structures of our lived experiences, we come to a fuller grasp of what it means to be in the world as a man” (van Manen, 1990, p. 12) with an eating disorder. In this study, the intention was to understand what it means to be a man in an age when body image seemingly takes precedence over other concerns, how attempts in achieving an “ideal body” affects one’s behavior, and the resulting consequences due to that behavior. This dissertation research found answers to the following questions:

- What was the etiology of each participant’s eating disorder?

- What prompted participants to get treatment?
- What was each participant’s experience of having sought and undergone treatment in a heterogeneous or homogeneous environment?
- How were participants’ perspectives altered through treatment?
- What interventions inspired participants to shift their perspectives regarding eating disorder behaviors?

Unlike quantitative methods, qualitative research seeks to discover the “what” and “how” of a phenomenon. In this study, the data gathered was based on the narratives of a few participants, unlike quantitative studies, which gather data from a larger sampling. Also different from quantitative research, was that a qualitative approach offered abundant evidence as to how individuals made meaning of experiencing the phenomenon in question. While this research does not allow for generalizability to all men with eating disorders, it does offer impressionable insights that can be used to inform future research and treatment. Using a phenomenological approach, the results of this study provided evidence that can be understood and applied to the treatment of men with eating disorders.

Theoretical Framework

Phenomenological method. Phenomenology is an approach frequently used to investigate the experience as it is lived, going beyond the content or objective details of the phenomenon being explored. Phenomenology studies an individual’s experience and the essence shared by all people experiencing a similar phenomenon; in this study, the phenomenon was the essence of males having eating disorders. Using the phenomenological method, participants’ stories were recorded to gain an understanding

of the process; in essence, going deeper to uncover the underlying meanings of the research participants' "lived worlds." The content of the stories offered a list of elements that made up the phenomenon, but not necessarily the participants' understanding of having a list; in other words, the content is the phenomenon at face value. The meaning-making process described the impact the phenomenon had on each participant. In other words, there was the information or content the individual shared, but there was also the deeper meaning or essence of developed attitudes and behaviors underlying the phenomenon. "To understand another person, phenomenologists do not inquire about some inner, subjective realm. Instead, understanding comes from asking how the person's world is lived and experienced" (Finlay, 2011, p. 3). This dissertation research composed a descriptive analysis explaining the men's lived experiences of having eating disorders in order to raise awareness and deeper understanding of this phenomenon.

Phenomenology is based on the writings of Husserl (1970), a German mathematician, who believed that scientific knowledge begins with an unbiased viewpoint of the topic. Phenomenological reduction requires the researcher to suspend personal beliefs and focus on the phenomenon as experienced by another person. Husserl (1970) called this undertaking to minimize biased interpretation "epoche." In phenomenology, the researcher suspends any preconceived notions about the subject matter to gain a deeper understanding of the phenomenon. In this way, the researcher approaches the lived experience with curiosity and an open mind, eliciting detailed descriptions and new insights. The epoche instructs the researcher to assume a neutral attitude, and set aside prior scientific assumptions to gain access to the participants' experiences as they encounter everyday life. Phenomenological reduction includes

bracketing, horizontalizing, texturally describing each theme, and finally, organizing the themes in a manner that brings the experience to light (Finlay, 2011; Husserl, 1970; Merriam, 2009).

Bracketing involves pulling from the participants' narratives key phrases and/or statements that convey aspects of the phenomenon. Using the individual's interpretation of these thoughts, their meanings are analyzed for what they reflect with regard to the experience. "Phenomenology holds that psychological reality -- its meanings and subjective processes -- can be faithfully discovered. Psychological realities need not be constructed; they have essential features that can be intuited and described by the research scientist" (Wertz, 2005, p. 175). The researcher suspends any scientific assumptions about the phenomenon, bracketing presumptions and remaining committed to describing the participant's experience. "This is a methodology that tries to ward off any tendency toward constructing a predetermined set of fixed procedures, techniques, and concepts that would rule-govern the research project" (van Manen, 1990, p. 29).

Horizontalizing or explicating significant statements that describe the elements of the experience (e.g., drive to be thin, perfectionistic tendencies, obsessive-compulsiveness) are not weighted, but instead given equal value, creating the possibility of viewing the experience from a new perspective. Moustakas (1994) explained horizontalizing:

Horizons are unlimited. We can never exhaust completely our experience of things no matter how many times we reconsider them or view them. A new horizon arises each time that one recedes. It is a never-ending process and, though we may reach a stopping point and discontinue our perception

of something, the possibility for discovery is unlimited. . . . Each horizon as it comes into our conscious experience is the grounding or condition of the phenomenon that gives it a distinctive character. We consider each of the horizons and the textural qualities that enable us to understand an experience. When we horizontalize, each phenomenon has equal value as we seek to disclose its nature and essence. (p. 95)

Moustakas (1994) is a widely cited phenomenological researcher, as his approach has proven to be accessible and seemingly favored by qualitative researchers. He stressed the importance of looking at the whole of the phenomenon and to examine all the data from many perspectives in an attempt to arrive at the essence from a reflective stance. “Phenomenological human science is discovery oriented. It wants to find out what a certain phenomenon means and how it is experienced” (van Manen, 1990, p. 29). My priority was to remain devoted to reporting the experience as accurately as possible. As a transcendental phenomenological researcher, I engaged in the following processes:

1. Identification of a phenomenon to study; in this dissertation, the phenomenon of men with an eating disorder.
2. Bracketed out one’s own experiences. In this dissertation, the primary concern was to gain an understanding of the male experience in recovering from an eating disorder. Suspension of my worldview was required. It was important to drop my own attitudes toward dieting, body dissatisfaction, and other characteristics of eating disordered behavior always by way of maintaining a heightened awareness of my own biases and assumptions concerning eating disorders and disordered eating behaviors. This is known as *epoche* and was

an ongoing process (Marshall & Rossman, 2011, p. 148). I made an intentional effort to refrain from judgment and control any bias, attitude, belief, presupposition, and experience I may have had around eating disorders, so that I could try on the experience from the interviewee's impression and report findings based on the primary source. Maintaining a journal provided a way to ascertain the bracketing of any personal subjectivity that may have influenced my analysis of the participants' narratives.

3. Collected data from individuals who have experienced the phenomenon. For this dissertation, the goal was to interview men with an eating disorder. The interview process was designed to gather experientially rich descriptions of the individual's experience of having an eating disorder.
4. Analyzed the data. Data analysis was on-going and began with transcribing the interviews and highlighting meaningful testimony. The methodological process included:
 - a. Any data that provided a deeper understanding of the phenomenon was highlighted and included as part of the horizontalization step; every meaningful statement relevant to the phenomenon was listed and considered to have equal value. From this list, emergent themes were created.
 - b. The data was then viewed from different perspectives "in order to distinguish essential features from those that are accidental or incidental" (Wertz, 2005, p. 168). A textural description of the participants' experiences (what participants experienced), a structural description of

their experiences (how it was experienced) and a combination of both to communicate an overall essence of the experience (Creswell, 2007, p. 60) was developed. Emphasis was on the experiences and concerns of the participants in an effort to base the analysis in their phenomenological reality. A final master list of emerging themes was compared to all of the transcripts to determine common themes among all of the participants. Overarching themes were identified along with significant quotes that reflected the main idea.

Phenomenology, Gestalt, and self-schema model. Gestalt theory is a phenomenological approach in which “all aspects of the field are potentially significant and interconnected” (Mackewn, 1997, p. 58). Using the self-schema model, issues of identity and self-definition can be defined and measured, analyses of how various factors function together in the formation of an eating disorder can be gathered, and how external influences (e.g., sociocultural environment) contribute to one’s internal messages regarding body shape and physical attributes (e.g., weight, muscular build) can be specified. According to schema theory, everything we sense are organized into schemas, or knowledge structures. However, each person’s schema is built through personal experience and therefore, is unique. “In Gestalt theory the central human activity is viewed as people’s need to give *meaning* to their perceptions, their experience and their existence” (Clarkson, 2004, p. 5). Using this model, the analysis of how men make sense of having an eating disorder can be specified.

A fixed Gestalt is a pattern of behavior or contact style that is out of one’s awareness and habitual. In other words, the ways in which an individual has learned to

manage a situation and respond even though the threat no longer exists is a fixed Gestalt. For instance, an individual teased for being overweight adjusts to the situation by way of diet and exercise. They are able to maintain a restrictive diet at the sensation stage in the cycle of experience through desensitization of hunger cues. This learned behavior becomes a fixed Gestalt when the individual no longer experiences hunger cues. A behavior developed as a creative solution to a true concern has become a fixed pattern of behavior as evidenced by its noticeable interference with one's ability to make different choices. The polarity of each contact style is the contact modification for the disturbances. As discussed in Chapter I, one can take either polarity too far and resistances may occur at any point in the cycle of experience.

In using the cycle of experience, the capacity to gain an accurate and intuitive understanding into how an individual's needs are fulfilled or interrupted are verified.

Data Collection

There is a great deal of information in the literature regarding the etiology of eating disorders including studies demonstrating a relationship with the media (Barlett, Vowels, & Saucier, 2008), peer relations (Polivy & Herman, 2002), family background (Koskina & Giovazolias, 2010), personality traits (Polivy & Herman, 2002), identity development (Bruch, 1973), genetic disposition (Peterson, Paulson, & Williams, 2007), emotion regulation (Allan & Goss, 2012), and the effects of dieting (Goodsitt, 1997; Valois et al., 2003). During interviews, participants of this study were asked questions to speak to each of these factors.

From their responses, each participant's beliefs about self and about self in relation to others were revealed. For instance, individuals reported gaining self-awareness

improved their ability to eliminate negative behaviors and improve relationships with others. The themes that emerged helped to better understand how one's concept of self was used to order their lives around an eating disorder. For the participants in maintenance/recovery, a better outlook and more positive self-concept enabled restored health. The literature demonstrated that eating disorders are often associated with negative beliefs about self, which impeded healthy identity development and manifested insecure attachment patterns. This study testified to the manner in which relatively normal functioning became disrupted due to environmental concerns along with the underlying dysfunctional mental processes contributed to the development of the eating disorder. Further, this research discovered how contact styles used to cope with a situation became problematic and fixed. Identifying the self-regulating patterns an individual exhibited offered greater understanding into the individual's way of being in the world.

Research approval. This study has been reviewed and approved by the Cleveland State University Institutional Review Board (IRB). A purposeful sample was used to ascertain information-rich cases. All participants signed an informed consent form for participation in the study. A copy of the approved Letter of Introduction/Informed Consent Form are contained in Appendix A.

Recruiting participants. Individuals were recruited through advertisement, specifically a flyer (Appendix B) that described the study and contact information. These flyers were distributed in person, electronically, and through United States Post Office mail throughout the State of Ohio to college counseling centers, eating disorder treatment centers and day hospital programs, mental health private practitioners specializing in

eating disorder treatment, and medical offices such as internists and dentists. An introductory letter to recruit participants accompanied the flyers, requesting practitioners to post or otherwise make available the flyers to their male clientele with an eating disorder diagnosis who were in recovery. Recruitment efforts were broadened to increase the probability of gaining enough participants to reach a point of saturation; of those that responded, six men gave their consent to participate in this study.

Participants. Participants for this study were males between the ages of 21 and 60 that had recovered or were in the process of recovering from an eating disorder (Anorexia Nervosa, Eating Disorder Not Otherwise Specified/Morbid Obesity), as currently defined in the DSM-IV-TR (2000). Additionally, all participants spoke English as their first language; there were no discerned communication issues.

To protect each individual's anonymity, only a blank Informed Consent form (Appendix A) is included with this document; each participant's signed Informed Consent forms were stored in a locked box that only this investigator could access. In addition to the data collected by way of the interview process, additional information was gathered through the use of the participant characteristics and demographics forms; an unmarked copy can be found in Appendix C. Due to the confidential nature of this study, the completed demographics paperwork, the unabridged transcripts of the interviews, and my journal, were also in the locked box. However, nondescript portions of the transcripts and my journal appear in Appendix D. Again, to protect the identity of the participants to

the extent possible, only a first name or a pseudonym was used to identify each interviewee.

The intention of this phenomenological study was to describe the phenomenon as these participants experienced the onset, treatment, and recovery process of an eating disorder. Van Manen (1990) explained:

A person cannot reflect on lived experience while living through the experience. For example, if one tries to reflect on one's anger while being angry, one finds that the anger has already changed or dissipated. Thus, phenomenological reflection is not introspective, but retrospective.

Reflection on lived experience is always recollective; it is reflection on experience that is already passed or lived through. (p. 10)

Confidentiality

Participants were assured confidentiality to the extent that no potentially identifying characteristics, such as place of employment, would be disclosed. Participants were told that interview tapes, transcripts, and any other identifying information were stored in a locked box to which only the researcher had access. Participants were also informed that all data would be destroyed after three years. Participants were provided a copy of the final study, if desired.

Method of Collecting Data

Data collection was designed to be as convenient as possible for participants. This included meeting with interviewees at the researcher's office, at a location more convenient for the participant, or by means of the internet using Voice over IP services, such as Skype. Individuals contacted me through email to set up interviews at a

convenient place and time for them. I met Scott at the nursing home where he resides. Chris was interviewed by way of Skype and Michael over the telephone. I met Jay at his office and Casey and Edward met me at a private practice office where I rent space.

I provided an explanation of the study and requested each interviewee to sign the informed consent form for participating in the study. Chris completed the Informed Consent and Demographics paperwork, scanned and emailed the materials back to me. I printed out hard copies. I read the forms aloud to Michael and received his verbal consent, of which I have an audio recording and transcribed copy.

All participants were informed that participation in this study involved a possible risk of increased anxiety and/or relapse in talking about eating disorder symptoms and reliving past experiences. The researcher strongly suggested individuals meet with a mental health professional to discuss any affective or cognitive difficulties experienced due to the interview process. Participants shared that they were either in contact with therapists or had a support system in place. Participants were reminded that participation in this study was strictly voluntary and that they could withdraw from participating at any time during the data collection process without any consequence. Furthermore, interviewees were sent a copy of the transcribed interview for final review.

Interview Protocol

Initial semi-structured interviews lasted 60 to 90 minutes in length and were audiotaped. The taped interviews were transcribed verbatim, coded, and analyzed phenomenologically. All interviewees were asked the same questions in the same order except for the first interview. Subsequent interviews began with an explanation of the interview process followed by the interview questions in the following order:

- What has been your eating disorder experience starting with how it began?
- How do you make sense of having an eating disorder?
- What was your specific diagnosis? How did that change over time?
- What do you believe impacted you most in your development of an eating disorder (Media? Peer relations? Family? Personality trait (e.g., low self-esteem, body dissatisfaction)?
- Were there cultural and/or ritualistic eating patterns established in your family of origin's household that may have contributed to your eating disorder behavior?
- How did other cultural issues contribute to your eating disorder behavior?
- What prompted you to get treatment?
- What type of treatment did you undergo?
- Describe your masculine identity with respect to having an eating disorder.
- What was your attitude toward treatment like?
- What type of medical care and psychotherapeutic interventions were received?
- How would you describe yourself now?
- How has your view of yourself changed?

The researcher, at appropriate times during the interview, asked clarifying questions and prompting questions that helped further clarify each participant's experience of having an eating disorder. The interview questions were in response to the research question and informed by the literature review, including the gap in the research with respect to men with eating disorders. Except for the collection of demographic

information, the interview questions were open-ended, non-leading questions. The intention was to focus on the individual's actual experience and not on general or stereotyped beliefs about eating disorders. A copy of the interview questions and the alignment with the five broad categories regarding how men make meaning of an eating disorder is presented in Appendix E.

Within two weeks following the interview, participants were given a copy of the transcribed interview to check for accuracy, as well as given another opportunity to add any additional thoughts or insights. I only received two replies. One participant responded, "I can't believe you typed all that. It all sounds great." Another wrote, "I finished reading through the transcript and I'm fine with the content. While I know that the actual interview probably generated choppy sentences, the content appears correct, and I am not uncomfortable with your use of any of the information." I appreciated that he caught a typographical error as well.

Data Analysis

During the interview, I made observation notes. Throughout the research process, I maintained a self-reflective journal, parts of which are included in Appendix D. "When trying to understand and interpret the experiences of others, the interviewer's self-reflections on how they feel during the interview and how they use their feelings and experiences, can provide insights that add to and enrich the research" (King & Horrocks, 2010, p. 130). My journal entries further supported the validity of this research.

In promoting reliability and validity, a member checking triangulation strategy was employed. The interviews, along with the researcher's observation notes and self-reflection journal, provided a means of triangulation and helped in confirming findings.

The researcher referred to a qualitative research expert to ensure the authenticity of the data analysis procedure and identification of any transference issues or biased evaluation.

Data analysis was on-going and began with transcribing the interviews and highlighting meaningful testimony. Meaningful testimony was determined by reactions experienced at the time of the interview; for instance, facial expressions, physical gestures, and changes in interviewees' demeanors were indications of something meaningful. I also noted content and process expressed by the interviewee's that resonated with my own thoughts and feelings. Any data that provided a deeper understanding of the phenomenon was highlighted and included as part of the horizontalization step; every meaningful statement relevant to the phenomenon was listed and considered to have equal value. From this list, emergent themes were created. The data was then viewed from different perspectives (imaginative variation) "in order to distinguish essential features from those that are accidental or incidental" (Wertz, 2005, p. 168). Free imaginative variation was a technique used to establish criteria for recognizing incidental details versus the essential elements associated with the etiology, treatment and recovery from an eating disorder. A textural description of the participants' experiences (what participants experienced), a structural description of their experiences (how it was experienced) and a combination of both to communicate an overall essence of the experience (Creswell, 2007, p. 60), was developed. Emphasis was on the experiences and concerns of the participants in an effort to base the analysis in their phenomenological reality. A final master list of emerging themes was compared to all of the transcripts to determine common themes among all of the participants. Overarching themes were identified along with significant quotes that reflected the main idea.

Self-Reflexivity

As a student in the mental health profession, I had many “aha” moments. The first came Summer semester, 2007, during a Psychopathology lecture introducing eating disorders. The professor shared a video clip that first aired on ABC’s *20/20* news magazine program on December 2, 1994 featuring Peggy Claude-Pierre and the establishment of The Montreux Counselling Centre Eating Disorder Program (Random House, n.d.). I remember watching the video and thinking that is the type of therapist I want to be – compassionate and effective. Not only did Claude-Pierre’s actions move me, but the stories of her patients had a deep effect on me as well. Their stories made known adaptive measures, like dieting and exercising, developed into an eating disorder and treatment is complex and lengthy.

The second “aha” came while I was reading vignettes from Shandler’s book, *Ophelia Speaks*. At age 17, Jessica Bulman wrote “searching through catalogues, you wish you could order the bodies, not the clothes” (Shandler, S., 1999, p. 2). I couldn’t agree more! While I have never been diagnosed with an eating disorder, I recognize my own dissatisfaction with my body shape and my weight. I find shopping for clothes so depressing because I am forced to have an awareness about my body shape and size.

My second year in the doctoral program afforded me an opportunity to intern at a treatment center for eating disorders. In addition to gaining experience in the diagnosis and treatment of women with eating disorders, I also was introduced to the knowledge that men can have an eating disorder, too. This was my third “aha” in that it initially really angered me that a man claimed to be just as affected as women in the drive to be thin. I have always believed that men do not have to worry about body image, as the

public appears to be more accepting of an overweight male in comparison to an overweight female. Even though the literature reported that eating disorders are nondiscriminatory, the majority of research pertains to the female experience. Where men are concerned, the literature mostly referred to gays or athletes. I believe my attitude at that time mirrored the research findings and societal views. As I learned more about eating disorders, I came to truly understand the term nondiscriminatory, which brings me to a fourth “aha” – how to be more aware of my own personal biases and be more critical of overgeneralizations.

Upon reflection, I am the type of person to advocate for the “underdog,” and appreciate the opportunity to give voice to a population that is seldom heard on the subject of eating disorders. My want is to contribute a perspective about treatment – what works and what doesn’t work and how individuals with an eating disorder prefer to be supported while working through their definition of self.

My fifth “aha” was that there are other treatment modalities beyond behavioral approaches. In discovering self, these approaches go beyond treating symptoms promoting psychological wellbeing from a holistic and emergent practice. Humanistic approaches are centered upon supporting individuals by way of validating one’s worldview. Through a collaborative effort, the therapist assists their patient in finding alternative strategies to enhance one’s quality of life in a way that is compatible with their natural way of being in the world. In focusing on personal strengths and redirecting efforts to capitalize on those strengths new possibilities and ways of responding to the situation emerge.

Summary

In review, the researcher's intent was to include the central phenomenological features into this study including: (a) an ability to set aside personal biases and held assumptions regarding the meaning making of eating disorders; (b) through interviews, gain access to the "lived world" as experienced by the participants using the phenomenological reduction strategy; (c) write textual and structural descriptions using horizontalization and imaginative variation methods; and (d) describe the overall essence of the experience without interpreting the participants' narratives. Per report, men are hesitant to seek treatment for eating disorders. The researcher was curious to learn: (a) what was the etiology and how did participants make sense of having an eating disorder; (b) what was the treatment experience including factors that encouraged the participant to seek treatment and what treatment involved; and (c) what fostered recovery and how is maintenance/recovery experienced. This study enhanced the scarce research regarding how men make meaning of their eating disorders and helped to better inform the medical and mental health professionals treating individuals with this disorder.

CHAPTER IV

PARTICIPANTS

This chapter presents the findings from the interviews with six participants identified as having an eating disorder. The participants were recruited through private practitioners, word of mouth, and posted flyers at eating disorder treatment centers, and through Twitter, Facebook, and Yahoo Group. Internet posts directed individuals to the research website where the flyer was reproduced. Appendix B includes the flyer used to recruit participants for this study.

The respondents consisted of six men between the ages of 21 and 60. I met Scott at the nursing home where he resides. Chris was interviewed by way of Skype and Michael over the telephone. I met Jay at his office and Casey and Edward met me at a private practice office where I rent space.

Interview Protocol Reflection

All participants were asked the same interview questions in the same order, except for the first interview with Scott. When I met with Scott, he was very willing to tell his story. I was hesitant in following interview protocol, and therefore, I found myself having difficulty mediating the interview. I was further intimidated and anxious with this being my very first interview representing the beginning of the data collection process.

On one hand, Scott made the interview easier because he was so willing to talk; but on the other hand, my nature made it difficult for me to interrupt. For instance, I would attempt to interrupt by breaking eye contact and looking at my research questions while asking aloud a question, but he responded as if he didn't hear me and continued with his train of thought. Regardless, I do believe I was able to attain all the data from Scott through his telling of his story. Because Scott was my first interview, I was able to learn from my mistakes and improved my interviewing skills.

One area of improvement incorporated clarity of interview expectations in my opening statements. All future interviews began with a statement like, "This is for research so I am asking the same questions to all participants. I'm going to go down the list of questions and answer them the best you can." By starting the interview process with this statement, the interviews went according to plan and the data collection and subsequent analyses of the data went smoothly.

Participants' Stories

The following is a brief introduction and the stories of the six brave men who participated in this study:

Scott.

Demographics. At the time of the interview, Scott was 39 years old and receiving care at a nursing home designed to assist individuals with morbid obesity. He is a Caucasian, heterosexual male, never married, and a member of the Seventh Day Adventist Church.

Etiology. At age seven, Scott suffered the loss of his father. While working in a prison as a prison guard, Scott's father was murdered by a convict. Scott was held back

from school the year that his father died. Approximately 18 months later, his mother entered into a new relationship. During Spring break, 1983, when Scott was around the age of nine, the family (his mother, her boyfriend, his brother and Scott) went on a road trip and the driver fell asleep at the wheel and crashed the vehicle. Scott was thrown out of the back windshield and suffered a deep cut on the side of his face. Due to the injuries he suffered, Scott was not able to return to school and was held back that year, too. He graduated high school at 20 years of age. “I truly believe when I was in first grade... the year when my dad got killed... we never had any counseling... I do think with all that trauma that has a lot to do with what’s happened with my weight... I guess food was a comfort.” Scott shared that he was “big in high school” and “never had any friends; it was home, work, school.” He also disclosed that he “was the shy person that would let someone run over me” and experienced being bullied often, especially in high school.

As an adult, Scott became a nurse and worked in a prison. In explaining his weight gain, Scott shared that he never ate that much, but the quality of his food choices promoted the substantial weight gain. Scott spoke passionately about his belief that fast food restaurants, and McDonald’s food specifically, “is very addictive... The ease of it, it was so easy on the way to work to grab something and on the way home.”

Additionally, Scott described his biological family (dad, mom, and brother) as overweight. To illustrate, Scott described his dad as a “gentle giant” standing approximately 6’ and weighing about 350 pounds. Scott’s body type sounded similar to his mom’s as he described her as being around his same height, 5’2”, and per his narrative, probably weighs about 220 pounds.

By age 34, he weighed 724 pounds. I was struck by his story of first being weighed by a nurse he met through nursing school:

...her husband owned a salvage yard, and I remember her taking me to the salvage yard after hours to weigh me to get a proper weight. Even though there was no one there, that was so humiliating. You know, thinking this is what a semi-truck would be getting weighed on for scrap metal...

Treatment. In the spring of 2008, Scott was forced to stop working due to being hospitalized for dangerously low oxygen levels; per Scott's account, his oxygen level registered at 30-40%. That was the moment he realized he needed help to get to a healthier weight; otherwise, as he reported, he would not have been able to restore his health. "I truly believe that if I had not come [for treatment] when I did, within six months, I would have been six feet under; I wouldn't be here. I wouldn't be breathing."

Through the assistance of hospital staff, he found a bariatric nursing center in another state, miles from his family of origin. He lived there for 18 months until he got so fed up by the taunting of another resident, he felt forced to find another nursing home. "I finally said you do something with him or I am out of here and their solution was he is supposed to be leaving in 3-4 months. I am not putting myself through that." Following several inquiries and working through transportation issues, Scott moved into a different bariatric nursing home and has lived there for the past four years.

Scott reported having a long history of cellulitis and needing help with cleaning bodily waste. Also, he required help with putting on socks and shoes, but for the most part, he shared that he was independent with everything else (e.g., showering). He was ambulatory, but used a rollator in case he needed to sit down; for instance, if he took a

walk down the hall and wanted to stop and talk with someone for a length of time, he would have access for a place to sit down with the aid of the rollator's seat. Scott also shared that he has a congenital malformation of the brain, Chiari Malformation, and surgery on the syrinx is a necessary treatment for this condition. However, at the time of the interview, this surgery was not scheduled. He reported the use of medication to relieve the pressure on his brain and resulting headaches.

Even though his treatment was encouraged by his mother, Scott shared that "I can't come back in that environment with the frozen processed pizza burritos;" so he has been away from home for five years. The treatment has been primarily diet and exercise, and Scott recognized the challenge of breaking old habits. In the nursing home, individuals often ordered take-out items, like pizza. "I never have any extra money and in a way that does get frustrating . . . not having any money to do anything with, but I think in some ways it is a blessing because that temptation is not there."

Maintenance/Recovery. At the time of the interview, Scott reportedly weighed 427 pounds. In addition to staying focused on nutrition and regular exercise, Scott also shared the importance of having outside support. He met a family through a 5K event.

I have a surrogate family now. They just live not too far from here, and it's the first time I have had anyone, I guess you could say, on the outside. ...I have some place to go (tearing up). I've never had that. It's pushing me to do better... before I do certain things, like eat something when I am not really hungry... I think about them.

Scott accepted this will be a life-long struggle, but expressed optimism in his recovery, citing "I have a career to go back to" and more to live for. He seemed to be

working hard to lose enough weight in preparation for bariatric surgery. “I want that other tool because I know every single person that has the full surgery in some point in their recovery, they think I can have this and you get sick. I want that tool. I know I am going to get sick if I have certain foods.” Further, Scott sounded determined to do everything independently. In addition to becoming fully independent, Scott also envisioned being able to experience social activities that he has not previously been able to enjoy.

Jay.

Demographics. When I met with Jay, he was 60 years of age and on the demographics form described self as Caucasian, heterosexual married male, raised in a Jewish home.

Etiology. Jay started showing symptoms at age 13, but did not understand he had an eating disorder until 13 to 15 years later. At the time of his suffering, eating disorders were not well understood by the medical or mental health profession. “Somewhere around 28-30 [years of age] I would say I had an understanding of what had happened.”

Jay shared that his behaviors started around the time of puberty and “by around age 17, he had started significantly reducing both food intake and food type... restriction was a primary behavior.” In high school, he actively participated in cross country running, and by around age 17, he had significantly reduced food intake and food type while he continued to participate in his sport. Per his report, his thoughts during that time became increasingly about food, body, size and shape. He recalled weighing himself incessantly, sometimes as much as four times in an hour. Food restriction and regular exercise continued through his college years. Midway through his second year of college,

he passed out during class and was taken to the hospital. He believed it was an episode of orthostasis, a condition in which unusually low blood pressure causes dizziness or fainting when someone stands from a sitting position because the brain is not getting a sufficient blood supply. No diagnosis was made of an eating disorder. He explained that at that time, the early 1970s, pre-DSM-III, men were rarely diagnosed with an eating disorder. Jay shared,

The experience was that I didn't exist... The disease didn't exist. I was as a person with the illness totally invisible. And that, it was weird, it was really weird. That was the main experience was how strange this is that this is happening and no one notices or seems to care. That is what the experience was.

Treatment. Jay was treated for anxiety and prescribed Valium. He lessened his exercise, but continued to restrict his eating. More importantly, he was able to develop a social network and shared, "that was positive for me and stopped my exercising behaviors at that time." His health improved. He applied and was admitted to medical school and disclosed that he lasted about three months before things fell apart.

Relapse. "For the first time in my life I experienced depressed mood," and this forced him to drop out of medical school. Through a unique set of circumstances, he got involved with the production of a play that was performed on the campus; and again, developed connections with others, this time focused on theater. While working on the play, he met his wife, an amazing cook, and "she made our relationship contingent on my eating everything she cooked."

Treatment. In an organic manner, Jay began the re-feeding treatment. He was able to return to medical school, and move forward with his career goals. From Jay's narrative:

What I was able to do was establish a set of connections with others through working on this play together, and during that time, I was working the play, um, I met my wife-to-be... she began the process of re-feeding me... I ate because I loved her and I trusted her and over the course of about two years, got up to a weight that enabled me to return to medical school and to restart my career.

Regarding treatment, according to Jay, it was nonexistent at the time. But even today, he needed to remind his current medical team, who are very well aware of his eating disorder history, not to ignore heart rate readings.

I am at that age when they give you a stress test, and my resting heart rate was like 55, or some number like that, and I told them not to ignore that. I said it should be around 60. Their response was, 'Well, it's okay, it is 55; you used to run cross country.' I'm like, no, no, no; it should be around 60... So, my current medical team is aware of it, but they don't know what to do about it. Nobody includes it in their thinking about me... I have to tell them how to think about it... that's universal. It's the nightmare of the field... I was told Michael Phelps has a low heart rate. He eats 12,000 calories a day. If you eat 12,000 calories a day and your heart rate is 42, okay, I'm with you... They don't make the connection.

Maintenance/recovery. Jay seemed very well versed on eating disorders, so he was able to describe his symptoms in agreement with the available research. For example, he shared that he “had all the things people with eating disorders had. I was highly ordered. I was perfectionistic. I was hypersensitive... I believe the biological studies. I believe the insulin studies... I think it just segued at some point into rigidity, and into malnutrition, and into endorphin release, dopamine and all that kind of stuff that happens when you are disordered.”

Jay described his recovery as “massively recovered, but it doesn’t mean I can’t recover more.” Overall, he described being able to trust hunger cues, being stabilized at a good weight, and “I think the ultimate measure of my own healing is in my ability to have this conversation, to take my own self-knowledge and to be able to utilize it for the good of others and to accept the feedback from others about whether it was working or not.”

At the time of the interview, Jay was involved with a group of professionals engaged in the dissemination of eating disorder symptomology and best practices for treatment. Jay’s story of recovery has a happy ending as he revealed being in relationship with another person “was more important to me than holding on to the disorder.”

Casey.

Demographics. Casey completed the demographics form including the following information: 55 years of age, Caucasian, heterosexual, divorced male with one teenaged daughter, and Christian.

Etiology. Casey reported that his weight was within norms as a child and he maintained his weight by way of actively participating in sports. As a teenager, he

remembered following a routine after school in which “I was typically at home on my own in the afternoon.. I would have a tendency to watch TV and just kind of sit there and graze on junk food.” At that time, Casey played a lot of sports so he didn’t gain weight. “I was a normal weight teenage kid.”

He disclosed that he gained weight following college when his lifestyle changed from a somewhat active and social (college) life to a lifestyle comprised of living alone, earning an income, and lacking in physical exercise. “It became slowly a bad pattern of nutrition and portion sizes. I think a lot of that is what it came down to and I just started to eat larger volumes of food at one sitting.” Casey remembered growing up in a German household where “big piles” of good food were served. When living with his grandparents for a short time, he reminisced about his grandmother “fattening him up,” as was her way of caregiving. Casey explained that when he graduated from college, was living on his own, and started earning wages was when he realized the financial means to purchase foods he enjoyed. He recalled that Hamburger Helper was one of his favorite meals, and he would make the whole box and eat it in one sitting.

Within a year of full-time employment and bachelorhood, he gained 40 or 50 lbs. “I can still remember [the doctor] said, “There’s two of you living inside of you.” He weighed 290 lbs. at the time. It really struck home when he made contact with others; for instance, he shared that he wasn’t self-conscious about his size until he was in a situation where he had to look for a new job.

He stated his German background might have impacted his tendency to eat larger portion sizes, but mostly, outside of the context of personal relationships with others

(e.g., his wife), body shape and weight was not that important to him. “I work hard, I make a good living, so my bad thing in life is I don’t eat well and I weigh too much.”

Casey explained that he gained and lost 100 pounds in his life. The first time was when he was looking for work; the second time, when he wanted to impress a woman, and then again, to keep the relationship, and lastly, for his health.

Treatment. The first time he lost weight was when he was in-between jobs and he was moving to a new city for work.

I became a little self-conscious of the fact that I was overweight... it was easy to become athletic again... I don’t know that I really curbed my eating habits as much as I exercised more so I burned the weight off and got back down to what for me was a normal weight, about 225 lbs. I became somewhat fixated, enjoyed the exercise, and enjoyed the running... bicycling... and so I was like, okay, I can control this, I’m in control... if eating too much or exercising not enough became a problem, I just rectified it and the weight came off.

Relapse followed by treatment. Casey shared that wanting to be in a relationship with a woman motivated him the second time.

I was a young guy and single and you knew if you were going to be a fat kid you weren’t going to find a good looking woman and so, I was more driven from that standpoint of, you know, you’re not going to be much of a find if you’re overweight.

Relapse number two followed by treatment. Once he got married, his eating habits were less of a priority, and it didn't bother him that he gained weight. However, as part of the relationship, his former wife encouraged him to lose the excess weight.

Relapse number three followed by treatment. When the relationship came to an end, Casey thought, "This relationship is done, so I'm not worried about what my weight is. It doesn't bother me... it was almost like saying, I lost the weight for you and now I'm going to gain it to spite you." In the Spring of 2012, "I broke the 400 lb. barrier." A laparoscopic surgeon was the "person to convince me" to have the bariatric surgery. The doctor said, "I'm going to give you the tool to make it happen."

And I kind of looked at that approach... I'm a construction guy and that's what he gave me, a tool. A tool that to some extent, forces behavioral change. And that's really what it comes down to, because I don't think I would ever have lost the weight without having the surgery. I don't think I had the discipline anymore.

Casey disclosed that having the tool (bariatric surgery) helped him to "follow the regimen of the right eating habits." In addition to having the tool, he also spoke about the positive reinforcement of losing weight. First, he spoke of the general good feeling of losing weight successfully. As "you're losing weight, you want to lose more." The tool offered the means to be able to lose weight and the positive reinforcement kept up his motivation. Another way Casey felt rewarded involved the compliments he was receiving from others:

...I was in a situation where someone hasn't seen me in a year... he walked into the door of my [office] and he just went, 'whoa, what happened to

you?’ And so, I told him, He, like everybody, is very congratulatory, supportive of it, and that just helps to feed the whole process.

Casey also shared that the experience has “been very positive in terms of what my confidence in myself and what I can do physically now compared to what I could before.” Prior to the surgery and subsequent weight loss, Casey had difficulty climbing ladders or fully inspecting construction sites where steps were involved.

Maintenance/recovery. Casey noted that his recovery:

...has kind of a reverse trigger where I don't have a physical striving for food, so therefore, when I'm busy, I don't eat. Kind of like the exact opposite, you know, whereas before I'd go, I'm hungry, and you know go to the snack machine or whatever and sit there and pump junk food into me. Now, I'm busy and I don't eat. And now it's like, it's 1:00 in the afternoon, I never did eat breakfast. I suppose I should have something for lunch. And I should hopefully eat something that's going to give me the nutrition that I'm supposed to have, so it's kind of a weird deal that the same things that triggered -- being busy, emotional distress -- that triggered eating, now can sometimes trigger not eating.

Michael.

Demographics. When we spoke, Michael reported that he was 44 years old, Caucasian, heterosexual, never married male. When asked about his religious background, he shared that he was raised Catholic but “I've changed to Buddhism, I guess, or Shamanism, either one.” He later shared that he has been attending a Buddhist center regularly.

Etiology. Michael's childhood sounded turbulent. Michael disclosed that he grew up in an unstructured environment; for instance, he shared that he remembered being left on his own to come up with meals. The family did not eat together and many meals came from fast food restaurants. He also described his mom as very loving and caring, but "there was a lot of yelling and stuff... it was kind of difficult at times."

Michael believed his eating disorder behavior started in second or third grade, but did not seek counseling until age 18. Michael explained,

I think I've always turned to food... I started delivering papers when I was 8, so it gave me access to more money to buy food... I was kind of overweight even before then... food was very nurturing. It was kind of always a nurturing thing. Comforting. It provided comfort... I think emotional support and... It became an addiction... I mean I was using it for emotional support but I was also using it because I enjoyed eating. It kind of snowballed... it kind of took on a life of its own.

Often left on his own and alone, he turned to food for comfort. Once he started earning money by way of delivering newspapers, around age 8, he was able to buy food as needed. Corresponding with this time period, Michael also watched a lot of television. From age 5 to about age 13 "that's all I did was watch TV." He spoke of the strong influence of television advertising.

I think the TV influenced me a great deal. I would consider myself, from maybe when I was 5 or 6 to I'd say about 13, when I was totally addicted to TV. That's all I did was watch TV... those 6 or 7 years, especially seeing all those commercials at such a young age, the influence was a lot.

While he initially sought food for comfort, it later snowballed into something he could not control and he spoke of food as an addiction. “It got to a point if you just suggested some kind of food to me, I would have to go out and get it. I couldn’t control myself.”

Michael described his dieting behaviors in this way:

I gained a lot of weight. I was constantly going on diets, though. So, I would go on a really strict diet for like a week and a half and then I would go off it, and I would be bingeing for a couple of months. Then, I would go back to a really strict diet for like a week and a half... I was exercising and lifting weights and stuff. I was delivering papers. I was riding a bike for 3 hours a day and yet, I was still significantly overweight... my diet consisted of McDonald’s, Burger King, pizza, cookies, sugar-coated cereals... not a healthy diet at all... it kind of hit another level when I got access to money.

He also shared a possible genetic influence. Per his report, his parents and his brother appear overweight. “I have an older brother... he has the same thing I do.” He also mentioned “my uncles and my grandmother... aunts... they are all extremely overweight.”

From Michael’s perspective, unhealthy eating is promoted in American culture. He shared that “healthy” foods, like fruit and vegetables, are very expensive while unhealthier choices tend to be cheap. “The problem with that is if you have an eating disorder, you don’t spend \$3 or \$4 at McDonald’s. You have to spend for one meal \$40.”

Treatment. Michael was able to lose weight his senior year in high school, motivated by his desire to go to prom; but following the dance, he started to gain weight. Relapse and Treatment. When he entered college, he slowly gained more weight. At age 19, Michael went on a liquid diet sponsored by a hospital. In five months' time he lost approximately 70 lbs., "but when they stopped giving the... liquid meals, I really didn't know how to eat."

Relapse and treatment. Without a specific nutrition plan, Michael went from 170 pounds to 290 pounds following the liquid diet. This catapulted him into treatment. When he entered primary care in 1991, he was given a diagnosis of Binge Eating Disorder without bulimia. From 1991 to 2007, he stayed on a prescribed food plan and maintained a good weight.

Treatment challenges. After a year of following the food plan, he still ended up having to have his gall bladder removed. It is his belief that his gall bladder failure was due to years of eating fatty foods and that eating healthy for a year did not reverse any damage done.

In addition, Michael struggled with living arrangements as he was undergoing eating disorder treatment a distance from his hometown. He stated:

I lived in somebody's house, um, for about a month, and they kicked me out, and I moved into somebody else's house... one of the roommate's there threatened to kill me... I moved in with somebody that graduated from [treatment place]... and he didn't want to live with me anymore.

Michael attributed his having to move around a lot due to his lack of income. "When you are poor, you are basically moving all over the place. You're constantly

moving, not because you're getting away from the rent. It's hard to figure out how you are going to survive."

Michael also reported having difficulty building a support network outside of family and therapists. He shared that his mom has always been a source of support. Michael felt that he had a lot of support at the treatment center and from his therapists,

Relapse number two and treatment. In 2007, credit card debt caught up with Michael "and things were coming to a head." He was able to find a job, but it meant he had to relocate. "I ended up moving to Washington State... but.. my support system was in Florida. When I moved out, I got very anxious and I picked up the food again." By 2009, he was able to get "abstinent on my own," but then he met someone through Overeaters Anonymous:

I met this woman, who I didn't really want to get involved with her. It wasn't really my intention, but um, you know, she kind of called me up and I would hang out with her and stuff and we would do things. And eventually, I kind of got to liking her, and um, but then, she pulled away at the last minute and that really hurt me.

Relapse number three and treatment. Michael relapsed following this break-up and ended up gaining 133 pounds. "I didn't get out of this relapse until Labor Day, September of 2012." He wasn't able to find a treatment center in Washington, so he returned to Florida for several weeks "and I've been basically abstinent ever since."

Treatment challenge. Michael made it known that his mother was diagnosed with brain cancer. During a visit with her, he shared "my family doesn't really take care of me

that well, so I can't get all the necessary foods I need to stay on the food plan. I'm kind of doing the best I can." He shared his concern for another possible relapse.

Maintenance/recovery. Michael is committed to consistent exercise, staying on his food plan, and practicing mindfulness meditation. "I'm very disciplined and dedicated when it comes to food and stuff... the other thing I've done is to supplement my spirituality. I think spirituality is another important factor."

Michael says he has been able to develop "a heck of a lot emotionally" and develop a lot of good friends, "like a lot of really good people." For Michael, recovery will mean having the ability to manage emotions. "If you cannot manage your emotions with an eating disorder, you will be crushed." At the time of the interview, Michael was doing the best he could to stay on his food plan including supportive friends, staying close with his therapist, and his Overeaters Anonymous sponsor. Michael recognized his need to involve others in his life to overcome his eating addiction and find fulfillment in his life, regulate emotions, maintain a diet and exercise plan and a consistent mindful meditation practice.

Chris.

Demographics. Chris was 24 years old at the time of the interview. He is Caucasian, heterosexual, in a relationship, and in medical school. He was raised Catholic but indicated "non-religious" on the participant characteristics and demographics form.

Etiology. Chris shared that his anorexic behaviors evolved as "something to control in a way [that helped] escape from other troubles or things you don't want to have to think about or deal with." He shared two separate experiences that happened during puberty, which led to his using an eating disorder as a coping mechanism. One

experience happened at school, in the United States, in which his peers teased him about his body size. “I didn’t think of myself as a very attractive person.” The second event, at age 12, he spent five months in Bolivia with his parents as part of a volunteer effort. Chris didn’t know the language and experienced difficulty connecting with people. “Really, I felt kind of alone.” As an extra factor, Chris described himself as overweight, and in Bolivia, “if you can afford to be overweight, then you are in a good spot” and this left him feeling “guilty about coming from privilege.” For Chris, it was also the first time he was exposed to that level of poverty. “I think I felt uncomfortable in a way about my privilege.” He started to lose weight while in Bolivia, but more from being “more active and eating different” foods.

I can’t really point towards one thing or one reason and in a way, when you go into treatment, you’re told reasons why some people... I’m trying to not have that influence me directly that I think that is exactly what it is, but if I could paint a picture of what is probably the closest thing, that’s probably it [escape from troubles]. Because when you are in the midst of it, you don’t understand why.

Upon returning to the United States from Bolivia, he received compliments, positive reinforcement, for losing weight and so, behaviors continued. For Chris, being overweight had “two very different vantage points from Bolivia being, you know, feeling kind of guilty about it, and then, in the States, for being teased by it.” As a solution to his social dilemma, he engaged in negative dieting behaviors. “It was more like, I just set an amount and for some reason, I convinced myself that was a good amount to eat.”

Chris shared that his mom is a professor of dietetics, and nutrition was highly valued in the family. Growing up, they always had meals together, and even though Chris would restrict calories, he would eat whatever the family was eating. Chris reported:

Even in my eating disorder, there was never a food I would never touch...

So, some people with eating disorders, they might lose weight like drastically, in a short period of time. But it was never like that for me. It was very gradual. I never completely stopped eating.

Chris described himself as an introspective/introverted personality. He also shared his struggle with having a voice and having the energy to be assertive. "I think I tried to work around it. At some point you, an outlet seems kind of nice."

Chris shared that initially body image was a motivating factor, but that at some point "I wanted it to stop, but I didn't know how."

Treatment. At age 13, he went to the doctor for a check-up and his heart rate was very low. The doctor explained to him that it would be unethical if she didn't institutionalize him, and so he was admitted to a children's hospital. This began his treatment for anorexia nervosa, which spanned three years.

...when you are 13 or 14 years old, which I was at the time, nobody is going to listen to you... I think they could have done a better job and like, I'm dissatisfied in the way they treated me... I think health care teams could do a much better job... People who do the group therapy sessions, they don't even look like they want to be there... it's bad, because you go in and you are already put into a box of what people say, what people with eating disorders is like, you know, or what their book says, or something

like that.. for me, I think that was the hard thing. It did get better. [Another treatment center] was a much better place to be...

Chris was diagnosed with anorexia nervosa December 2003. He explained his treatment path as follows: First, he went to the Children's Hospital. "I wasn't gaining weight fast enough," so they inserted a feeding tube before discharging him to a center in Maryland, "one of those in-between hospitals." When he was discharged, he went back to school; however, he continued to struggle so he was admitted to a center in Ohio.

Maintenance/recovery. In full recovery by age 19, Chris has been out of treatment for 5 or 6 years, and shared "I am able to follow my body cues and my hunger cues, and you know, I'm just happy I got to that point." He stated, "Knowing and accepting" has given him peace of mind. While old habits of restrictive eating and excessive exercise are nonexistent, there are "little things I struggle with, that are social or of trying to feel included or being listened to."

Chris acknowledged that if he hadn't gone through treatment, he would not have been able to recover on his own. He mentioned having a good therapist and a supportive family as being two important factors in the recovery process. Chris also stated: "the biggest thing was having a supportive community... those who are willing to listen to your story and hearing what you have to say." Chris shared that the experience had helped him better understand the struggles others may face and as such, he developed a greater capacity for empathy.

Addressing issues of masculinity. Chris spoke about having to deal with assumptions people have about "being a guy" with an eating disorder:

I never felt really weird being a guy in a center for eating disorders. I felt weird about, being more self-conscious about being a guy outside of that... I don't know what kind of assumptions people have, but I think... they might think that guys that experience that are more feminine or... they are totally obsessed with their image... I think that is kind of a vast exaggeration they made for all people with eating disorders whether male or female.

Edward.

Demographics. Edward, a Caucasian, single male from a Christian background, was 21 years old at the time of the interview. He identified as being heterosexual, and added on the participant characteristics and demographics form identifying with being “gender queer.” He explained:

I mean gender queer is definitely a concept that I am still understanding about myself. I think when I say gender queer, it's that... it's... there's a lot of, I guess, social norms regarding gender that somehow I just don't see sometimes and so that has led to some very, um, difficult interactions with people who don't necessarily accept my viewpoints. I think that is why I put gender queer. I mean it definitely is part of the LGBT community as a whole. It's just, um, yeah, trying to figure out my place inside the norms of everything.

Etiology. At age 10, while away at camp, a male counselor sexually abused Edward. His negative diet behaviors stemmed from wanting to feel empty, which reflected his emotional state at the time. He shared his camp experience:

I think the reason why my head connected eating with the abuse, was because they were really dumb there. Every meal they had, they had this weird thing where it was like we are going to measure everything you don't eat and weigh it out so you can see how everyone is wasting stuff. So, that basically clicked in my head and said, you know, what, I don't want to waste anything and so I'm just not going to eat anything. So, I think that is how everything got connected together.

As Edward moved through adolescence, he became more influenced by societal messages about the ideal male body image. Thoughts about body shape and image influenced his choices around exercise. He began cycling and running and joined the Drill Team.

I guess in America, around age 16, there's that huge movement of, you know, this is bad food and, you know, do this and you'll live a better life type thing, and so I definitely grabbed a hold of that and used it to... let the eating disorder have more justification, because the message that I guess society was giving me was that an eating disorder wasn't harmful. It was actually what it was supposed to be and, you know, I was a winner.

Per Edward, his mindset was along the lines of punishment; for instance, if he would eat this perceived unhealthy food item, it would be like a punishment to his body. So instead, he justified his harmful diet by claiming that he was eating "healthy." "At one point, I was basically only eating fruits and vegetables."

In describing his personality, Edward shared that he tends to be more introverted and has a strong appreciation for mathematics, his college major.

...that's something that I absolutely love just because that kind of is the whole mindset with mathematics... like floating down the river happy.

You can do whatever with it whenever. You don't need anything complicated. You don't need to set up this scientific thing. You know, you can just perceive anything and use math to talk about it.

Treatment. From age 10 through the time of the interview, Edward has been receiving treatment, albeit not always specific to the eating disorders. The same doctor that he had since age 10 never suggested that he had an eating disorder until he was so ill he had to be hospitalized. At age 16, his heart rate dipped below 30 beats a minute and his "weight was terrible." While taken to the hospital, his visit was spent in the cardiac wing. He did see a therapist following that hospital stay, but "she was never really treatment focused. It was more... family therapy... I would say my very first experience with it was that no one knew what was really happening" and this was very frustrating for Edward. His next hospital stay, at age 18, was due to auditory hallucinations that he experienced during his first year of college. Following a short hospital stay, maybe 10 days, he entered into an eating disorder treatment program, which lasted three months.

Even at age 16, I had gotten the eating disorder diagnosis, so my family and I knew it was an eating disorder, but... I never really encountered professional specialists for it until [his second hospital visit]... Following my last day at [treatment center]... I was, like my mind, I need to get back to college so I can do behaviors again. That was the mindset. And so, that's exactly what I did... I was down in college with my sister... I was writing a letter to a friend... mentioned... having trouble with behavior... I

mean literally, I don't know if I would be alive if I wouldn't have fallen asleep and left it on my desk for my sister to read the next morning, because basically, that day my parents picked me up, took me back to the hospital.

Relapse and treatment. Edward spent 60 days in a residential treatment at a center that had a specific program for males. Edward spoke of a specific treatment intervention that he believed “is really the reason I am alive... because somebody literally worked with me to change my behavior and challenge my thoughts.” The specific intervention was Exposure Response Prevention (ERP) and per Edward, “that really provided me with the tools I needed to create the recovery for myself.” He also stated that it was equally important “that somebody was actually trying to understand me and that’s really all that I cared about.” He also spoke of being comforted by another patient who he described had his back. He said, “If I didn’t have someone to back me up, I would have been absolutely miserable and would have just shut down.”

Maintenance/recovery. Edward recognized that recovery is a slow, long process. He has not had aggressive behaviors, like purging, and since treatment, and he reportedly continued weekly talk therapy and maintained a good weight to prevent relapse. Edward reported some struggle with restrictive dieting behaviors, but the motivation driving behaviors has dissipated.

Now, I’m definitely still learning a lot about life, because my eating disorder, basically was from age 10 to age 19... I didn’t really develop a lot emotionally and like, identity-wise. And so I’ve been... slowly progressing and understanding more about me and getting back to normal

life for a 21-year-old... wanting to accept both my body, my thoughts, my perspectives, and not wanting to have a struggle with it anymore.

Edward is especially grateful to one of his behavioral specialists because she “made recovery fun,” and that resonated with Edward’s sense of wanting to exhibit his true nature of a “happy-go-lucky attitude.” Overall, the support he received from treatment providers helped him to recovery.

Disclosing diagnosis to others. Edward had the following to say about disclosing diagnosis to others:

I’ve always seen it more as a, you know, disease isn’t the best word for it, but definitely something that wasn’t something I wanted, just like a person doesn’t want to have cancer or something like that. And so, I think I’ve seen it more as a disease probably to hide behind the social stigma of it because if it is a disease, I think I say to myself that it should be more acceptable in society, but at the same time knowing that it is... a mental health condition as well. I mean it was again around that age 16 or so you know when I was officially diagnosed and I had to take time off from high school and what not. I think it was definitely something I never really held on to as in like this is who I am. So, it never became like an identity for me, it became more of a, I guess a source of judgment... if I were honest to people my age in school about where was I and all that stuff, for instance, my best friend, you know, he would make really bad jokes about it all the time and eventually he just never talked to me again. And so I think it supported the notion you just can’t talk about it. And I think anyone, male or female with an eating disorder that you just don’t talk about it.

Outside of treatment, Edward reported that he struggled with relationships, “especially with people my age.” He didn’t describe self as shy, but instead, has learned to shy away from people. “I don’t want to be that way, but I’ve learned that sometimes it hurts when I don’t get the, um, I guess response or, you know, the friendship that I’m wanting.” Edward told of discouraging experiences when he would share with possible friends that he is recovering from an eating disorder. “I would say a lot of them... treated it like I should be quarantined, to put it in best words.” He shared that people’s perspective of the disease was really negative and that individuals suffering were more of a burden than a friendship would be worth. In Edward’s words, “you are like a lame horse.” Even within his own family, Edward’s struggles were “kept in a jar,” so his support group befell on treatment providers.

Eating disorder stigma. Several participants addressed the negative assumptions people have about eating disorders. It seemed, in some cases, that the participants’ disordered eating behaviors started as a way to fit in; for instance, to meet the criteria for being deemed attractive, only to later learn they are a social pariah for being labeled “anorexic” or “obese.” The participants expressed a sense of being deemed socially unacceptable, either for being overweight, morbidly obese, or having been diagnosed with an eating disorder. Further, one participant spoke about the misperception people have that individuals choose to have an eating disorder.

No one chooses to have an eating disorder. There is sufficient evidence demonstrating that negative dieting behaviors can and do trigger a biological malfunction in maintaining a healthy weight (Dottan & Zubery, 2009; Peterson, Paulson, & Williams, 2007; Polivy & Herman, 2002) and each of these participants described a “point of no

return” or a sense that they could no longer control their dieting behaviors. Chris shared a story that I believe helped to put in perspective how individuals, even those studying medical and mental illnesses, deem eating disorders as a choice:

I was with a student organization; they go to different sites -- some poor people, some with mental disabilities... there was this one time... with [an eating disorder center]. And, any ways, I thought that would be interesting, I'll go... It was interesting to me to see another Center and kind of think about it from my experience. Well, I never shared... that I had treatment or anything like that... what I find interesting and I don't take it personally anymore, but it's interesting hearing what other people say about people with eating disorders. So like, we are driving back and this other girl, another medical student, um, I think we started talking about the reasons, you know, people go into it. So, this is interesting, I'll just hear what they have to say. And she said something like, um, I just think people choose to... have an eating disorder or something like that. I was kind of like shocked, because, really? You think people actually wish to put themselves through that and go through that struggle. She like talked about some example of some girl she knew, an undergrad or something like that and to me, I don't know, that just sounds so ridiculous to me, ah, but I think that is often fed by, because she knew her friend obsessed about her image, she seems to think that really it's a choice, because she is so obsessed about her image. And it just kind of blocks out

the complexity of it all. Um, and how for people it is a proxy of what they are thinking about, when in fact, it is much more.”

Additional participants. There were additional possible participants for this study that I did not interview. For instance, a colleague connected me with a nursing home that cares for individuals who are severely overweight and waiting to have bariatric surgery. The recruitment flyer was posted and I was surprised that the contact person at the nursing home let me know that seven nursing home residents were interested. At this particular site, individuals let the contact person know of their interest rather than each contacting me individually. Scott was my first interview, and I was surprised that he had already read and signed the Informed Consent, which I provided to my colleague when I first told him about my study. When I visited the nursing home to interview Scott, the nurse that was helping coordinate the interviews showed me two additional signed consent forms and knew of others that were open to speaking with me. However, from my interview with Scott, I realized that individuals at the nursing home were not being treated for an eating disorder; but instead, they were there for assistance with conditions manifested by obesity including respiratory issues, cellulitis, and limited mobility. I was under the impression that they were on a wait list for bariatric surgery, but it may be a year or longer before they actually have the surgery. I was not confident that these participants met the criteria for this study in that they were not near recovery or maintenance.

I might have gone back to interview the other interested nursing home residents to learn more about the etiology of obesity and how individuals make meaning of their current condition if not for the challenge the winter weather presented during the time I

was conducting the interviews. I made an attempt on two different occasions to return to the nursing facility and both times, frigid temperatures and poor road conditions prevented me from doing so. Furthermore, on one occasion I was set to leave for the nursing home when the nurse called to let me know they had lost power and started an evacuation process. In the meantime, I managed to make contact with other participants interested in the study, and I never returned to the nursing home to conduct more interviews.

There were other missed opportunities to include other participants to this study as well. For instance, a possible participant contacted me through email, and inquired about my study. I responded, but never heard back from him. This happened again with another individual; a white, 50 year old male diagnosed with binge eating disorder contacted me through email. I replied to him on three different occasions. On February 3, I attached the Informed Consent along with a brief description of my study. When I didn't hear back from him, I emailed him again on February 15 to inquire if he was still interested, and on March 10, I tried one more time to connect with him. He did not attempt to contact me on any of those occasions.

I had completed my data collection at the end of March and was well into my analysis and the writing of this chapter when I received an email from a 28-year-old male diagnosed with bulimia nervosa. He shared in his email that he has been in and out of treatment for the past six to eight years. I very much wanted to learn of his story, but I could not see how I could have added another participant as I had already come to some conclusions from my data. I made the decision that it was too late for me to include him in my study.

As mentioned earlier, I posted messages on Twitter, Facebook, and Yahoo Groups to recruit participants for my study. I did receive an email from an individual diagnosed with bulimia nervosa and night eating syndrome. I sent him the informed consent, but he did not make further contact with me. In one case, there was a strong negative reaction in which the individual responded, “Gentlemen, we may have a leak in our . . . anonymity.” While I did have permission from the site administrator to post my research request to seek participants, I deleted the message, as I wanted to respect the members’ wishes for absolute anonymity.

Summary

Regardless of the diagnosis of each participant, I was struck by the use of diet and exercise as a coping mechanism for each individual’s experience of their environment and in their way of relating to self and others. In each case, participants alluded to a sense of isolation or being left alone regularly and this seemingly led to unhealthy eating patterns. Interestingly, in each case history, treatment was not considered until an emergency situation resulted. Treatment modalities were similar regardless of diagnosis. In each case participation in group therapy was practiced as well as a strong focus in healthy nutrition and the use of behavioral measures to encourage healthy diet behaviors.

With regard to recovery, each participant spoke of an impactful relationship. Through developing a healthy relationship with another individual, healing and recovery from the eating disorder was made possible. Relationship seemed to be a primary factor in recovery, and of equal value or a secondary factor was a “tool;” for example, the tool of bariatric surgery or the tool of a specific intervention like ERP.

These themes are explored further in the next chapter by way of the theoretical framework explained in Chapter III.

CHAPTER V

FINDINGS AND ANALYSIS

Interview Introduction

Chapter IV described each participant's story. This chapter addresses the participants' stories in relationship to themes expressed in the research questions. I think it is important to note that for each individual participant there were different environmental triggers, but the symptoms of their eating disorders were similar. Participants in this study gave voice to a broad range of eating disorders, from anorexia nervosa to morbid obesity. Additionally, the age range of the participants was expansive, offering a historical view of treatment for eating disorders during the 1970s compared to the treatment offered today.

The purpose of this dissertation was to provide insight into the male experiences of having an eating disorder through the eyes of these six participants as a means to promote the nondiscriminatory nature of the disease. This dissertation study further explored understanding the interdependence between self-concept and eating disorders. As discussed in Chapter I, several broad theories have appeared in the literature in an attempt to explain eating disordered behavior. This dissertation's overall research question, "how do men make meaning, from etiology to recovery, of their experience in

having an eating disorder,” was addressed by asking participants to respond to five broad categories of questions, covering the etiology, treatment, and recovery/maintenance of having an eating disorder. The research questions were developed to respond to each of the theories discussed in Chapters I and II, including sociocultural theories, family influences, co-morbidity factors, such as emotional dysregulation, and self-identity and effectiveness theories. As the literature review indicated and the participants of this study confirmed, there is no one factor that explains eating disruptions, but several working together in concert.

This chapter continues with sections pertaining to creative adjustment, self-concept disturbances, and a sense of belonging. The chapter then continues with the identification of themes drawn from the six interviews. These themes are organized to reflect etiology, treatment and recovery stages of an eating disorder as described in this dissertation.

Creative Adjustment

Relating to the world around us begins as soon as we are born. A baby’s first cry yearns for attention and care. As humans develop, the cry or contact style used to gain attention is constantly regulated or modified relevant to the situation. As infants, we may cry until our needs are met; as children, the creative adjustment may be to give words to the distress. Habits or behavioral patterns take form when ongoing and repetitive needs are addressed in the same fashion; for instance, when under stress, some individuals turn to food. For each participant in this study, adjusting to psychological stress amounted to either restricted or unrestricted eating as a coping mechanism. This adaptive behavior became the established way of being and fell out of their awareness. The incurred

negative consequences (e.g., low oxygen levels, low heart rate, auditory hallucinations, morbid obesity) seemed to take each by surprise. Further, once the habitual behavior was acknowledged, individuals recognized the difficulty in changing their maladaptive behaviors.

Participants of this study referred to ways their eating disorder behavior helped cope with negative thoughts and feelings. Several participants spoke of food as a way to feel comforted, nurtured, and in one case, specifically called food “a friend.” For those who engaged in emotionally eating, a sense of comfort and being “fulfilled” emerged. Chris stated, “I think it was more something to control in a way if you I think in a way you can escape from other troubles or things you don’t want to have to think about or deal with.” For individuals engaged in restrictive eating habits, a euphoric sense of victory was experienced. Edward spoke of being a winner as he was the thinnest among his peers and Jay expressed “the rush of restriction is incomprehensible.” Regardless of individuals’ responses of either eating or not eating, they reported that their behaviors tended to a host of emotions like boredom, indifference, disappointment, cruelty, anger, helplessness, shame, and guilt. These seemingly opposite ways of responding to conflict, eating or not eating, may be rooted in self-concept.

Self-Concept Disturbances

Negative schemas developed from unmet core emotional needs. In the case of eating disordered behaviors, three types of self-concept disturbances were identified in the literature: (a) identity disturbances, (b) body image disturbances, and (c) self-esteem disturbances (Stein, 1996). Bruch (1973) was first to discuss the potential negative outcomes the conflicted child experiences in making sense of the parent-child dynamic

while establishing a separate and stable sense of self. In the scenario of particularly controlling parents, the child's autonomous development is limited because the focus is on following directions versus getting needs met. The parents define the child's self-concept. This, in turn, establishes a dynamic whereby the child consistently looks to others to define self. This behavior is apparent in individuals who wait to be told what to do and then, always act in accordance to the instructions giving rise to a sense of being nobody and overwhelming feelings of incompetence and self-doubt. Edward's experience resonated with this notion:

I would say my view of myself went from not being a person... I would always have the disconnect between my body and I guess more of what was in my head and I would always say I don't want this body because of what happened to me... it definitely progressed from not wanting to be a person to then around age 16, wanting to be like the super man or something... I had hopes of being an officer in the Air Force... I really only wanted that just to... prove to others that... I was capable of being someone. And then, it developed into just wanting to be peaceful about myself. Wanting to accept... my body, my thoughts, my perspectives and not wanting to have a struggle with it anymore.

Other theories (Cash & Pruzinsky, 2002; Stein, 1996) explained different reasonings for a lack of development of the autonomous self; however, much of the research reflected the importance of autonomous maturation as a basis for moral development and taking responsibility for one's actions (Stein, 1996). According to the Gestalt theorists,

The most profound discoveries or learnings take place when the person is self-directed (rather than directed by others), when he supports himself, and when his total sensory-motor organism participates in the process. This kind of learning can come only from a personal framework which carries a respectfulness for one's uniqueness and integrity. (Zinker, 1977, p. 85)

Body image disturbances, highly experienced during puberty, can stem from subjective experiences and can reflect one's attitude about the actual or perceived viewpoint about self in relation to one's body. Individuals with body image disturbances incorrectly judge the size of their own physique. Behavioral responses to a negative body image attitude range from ignoring the body (e.g., avoiding mirrors) to obsessing over one's image (e.g., compulsively weighing-in). Scott reflected, "In the bathroom it was hard to look at myself in the mirror because when I looked at myself in the mirror... I know I was that big but I don't think in my mind I really knew I was that big." Jay's experience exemplifies obsessing about weight as he explained, "my thoughts over age 16 to 17 were increasingly about food, body, size and shape... by around age 17, I had started significantly reducing both food intake and food type... while I continued to run... I began weighing myself constantly. At the worst I would say up to 4x/hour; certainly, never less than daily."

For the eating disordered individual, body image attitudes become enmeshed with self-worth (e.g., "Because I'm fat, I'm a failure"). Michael stated, "I didn't feel good about myself, and I think that's what basically contributed the most to my eating disorder. I just did not have any self-esteem or self-awareness." Self-esteem disturbances can

include negative attitudes toward self and low body satisfaction. Scott talked about having a “double whammy... my weight plus being a man.” Directly related to being teased by his peers for being overweight, Chris disclosed, “I didn’t think of myself as a very attractive person.” Low self-esteem is a strong factor in the etiology of eating disordered behavior. Descriptors associated with eating disorders include a “bad me” schema, in which organized patterns of thoughts and behaviors tend to be negative; for instance, “I’m not worthy,” “I’m not good enough,” or “people will reject me.” Even in the face of contradictory information, these individuals may interpret experience as having failed.

Michael’s testimonial is a good example of low self-esteem, a negative self-concept, and struggle to positively reframe a situation. When asked what impacted him most in the development of an eating disorder, he responded, “I didn’t feel good about myself... I just did not have any self-esteem or self-awareness.” After being abstinent for several years, he relapsed following a broken relationship: “She just pulled away. She just didn’t want anything to do with me.” Michael reflected, “I didn’t have any support and that emotionally, just killed me. And then the last day of 2009, I turned back to the food. And that was a bad relapse.” His projected mood of feeling rejected, misunderstood by others, and emotionally hurt is evidenced further by his statement, “I think I might have went to see a therapist or two, but they didn’t know what the fuck they were doing.” I interpret this as Michael feeling he failed even if a professional or others tried to tell him differently. Talk therapy is less effective when individuals are not stabilized.

A Sense of Belonging

Maslow (1954) diagramed the basic needs for wellness attainment, which included having a sense of belonging. Self-worth and confidence, per Maslow's theory, can only arise through healthy community relationship. When love and acceptance does not emerge naturally or a sense of belonging is not experienced, the individual will strive with great intensity to fulfill this need. Individuals presenting with this self-belief tend to be hyper-vigilant in situations presenting as a potential for rejection. As such, it becomes vitally important to gain other's approval. As Edward said, in striving to do everything exactly right, "I just overdid it."

Theme Identification

From the six participants' responses to the interview questions, themes emerged that related to the overall Research Question of this dissertation: "how do men make meaning of their eating disorder from etiology to recovery?" Themes were drawn from the participants' interviews based on word repetition, such as "tool;" or categories, such as "personality traits;" or themes, such as "invisibility." I also looked for metaphors and analogies participants used in explaining their experience as men with an eating disorder. While the stories of the six men who participated in this dissertation research offered evidence of a combination of the theories and factors described in Chapters I and II, the phenomenological lens used here was focused on the individual's actual experiences more than their general knowledge and beliefs.

Chris described the challenge of making meaning in his statement, "When you are in the midst of it, you don't understand why." He further explained that when he went into treatment, mental health professionals attempted to explain why he developed an eating disorder, so his intention was to not let this influence his responses. However, this

thought left me questioning other participants' objectivity in making meaning of their illnesses. For instance, at the time of the interview, Jay was 60 years of age sharing his experience of some forty-five years ago. Furthermore, he has shared his story several times before meeting with me in his current work advocating for individuals with an eating disorder. As Bartlett (1932) explained in his schema model, individuals reconstruct memories to reflect current beliefs and attitudes. Schacter (1999) demonstrated seven shortcomings of memory including misattribution in which individuals may correctly remember specifics about a past event but attribute those facts to a new context. The meaning Jay made of his experience with having an eating disorder may be demonstrative of reconstructed memories.

I examined my own assumptions and knowledge about eating disorders through self-reflection and journaling. I set aside any expectations concerning my understanding of eating disorders before meeting participants, and based my impressions on my immediate experience. I recorded my thoughts and feelings immediately following interviews in my journal. Each interview transcription was completed within two weeks of meeting with each participant. Once I transcribed the data from an interview, I emailed a copy of the transcript to the participant checking for accuracy and offering an opportunity for him to make any additional comments. Scott responded: "I can't believe you typed all that. It all sounds great." Casey noted a typographical error and wrote, "I'm fine with the content." The others did not reply, and I took that to mean they accepted the copy.

The process of identifying the themes was accomplished by highlighting pertinent quotes in the transcript and noting possible themes in the margins. Once I collected all of

the data, I then went back through comparing themes among the six participants. I created a chart for clarity, which appears here. Each of the identified themes is described in more detail in the following paragraphs.

Table 1 describes the age of onset for each participant’s eating disorder and their diagnosis. Individuals diagnosed at an age different from the age of onset, the age diagnosed was noted along with the diagnosis.

Table 1.

Participant’s age of onset and diagnosis.

Data	Scott	Jay	Casey	Michael	Chris	Edward
Age	Childhood 7	Puberty 13-14	Adolescence 14-15	Childhood 8-9	Puberty 13-14	Childhood 10
Diagnosis	Morbidly Obese	Never officially diagnosed; AN	20s; Morbidly Obese	18 y/o; Compulsive Overeating/ BED w/o bulimia	14-15 y/o; AN	16 y/o; AN 19 y/o; EDNOS

Data Analysis

Etiology. To best understand the etiology of the eating disorder, factors, such as sociocultural influences, genetic proclivities, and environmental roles, were explored to discover the essence of the set of causes for the onset of each participant’s eating disorder.

Interviewees’ responses helped me to further understand and appreciate the difficulty in capturing the essence of having an eating disorder. I recognized there were several factors working in concert attributing to the origins of an eating disorder disease. While childhood and adolescent development appeared to play a large role for

participants, other common themes included personality traits, contact styles of relating to others and/or the environment, and creative adjustments individuals made to fulfill unmet needs, like a sense of belonging, became apparent.

Table 2 identifies a quote from each participant's interview as to how each participant made meaning for the development of an eating disorder and the themes drawn from the research questions pertaining to the etiology of an eating disorder. These themes comprise of family/genetic influence, peer influence, media influence, cultural influence, trauma-related influence, physical/body awareness, and personality traits.

Table 2.

Participant’s meaning making quotes and etiology themes drawn from the participants’ interviews.

	Scott	Jay	Casey	Michael	Chris	Edward
Meaning Making of having an eating disorder	A mix of things including the “loss of my dad at a young age,” “using food as a comfort,” the “poor quality of the food”	“I think purely biological.”	“I really didn’t make sense of it.” Behaviors became habitual; didn’t notice weight gain until seeing a photo.	Initially, used food for emotional support, then later it became an addiction; “It kind of snowballed.”	“Something to control in a way you can escape from other troubles or things you don’t want to think about or deal with.”	“I’ve always seen it as more of a disease.”
Family/ Genetic Influences	Poor nutritional diet growing up; no food restrictions or boundaries or diet discipline. Family history of overweight/ obesity	Denied influence of Jewish background “more food than anyone could ever eat” “I think I was just wired that way . . . I believe the biological studies”	German background; larger portion sizes normalized It just happened; “didn’t notice until I saw a picture of myself”	Poor nutritional diet growing up; no food restrictions or boundaries or diet discipline. Family history of overweight/ obesity	Mom is a dietician; nutrition and family meals valued. Family history of ED on maternal side –female cousins. “I think it just kind of happened”	“Least cultural family” “Unfortunate to have this specific genetic trait and given the right environment, it just happened”
Peer Influence	Teased and bullied; no friends growing up and few friends now	Difficult to keep relationships together when disordered; was able to create a supportive network; wife very supportive	Relationships tend to be motivating factors to diet	Growing up he was pretty much alone; food was companion. Has developed a friend network and OA sponsor	Negative impact for being overweight in both the U.S. (teased) and Bolivia (privileged)	Influenced by male ideal body; sensed others’ negative assumptions about ED; kept ED “in a jar”; struggle with male relationships and socially networking

Table 2. Participant’s meaning making quotes and etiology themes drawn from the participants’ interviews (Continued)

	Scott	Jay	Casey	Michael	Chris	Edward
Family/ Genetic Influences	Poor nutritional diet growing up; no food restrictions or boundaries or diet discipline.	Denied influence of Jewish background “more food than anyone could ever eat”	German background; larger portion sizes normalized	Poor nutritional diet growing up; no food restrictions or boundaries or diet discipline.	Mom is a dietician; nutrition and family meals valued.	“Least cultural family”
	Family history of overweight/ obesity	“I think I was just wired that way . . . I believe the biological studies”	It just happened; “didn’t notice until I saw a picture of myself”	Family history of overweight/ obesity	Family history of ED on maternal side –female cousins.	“Unfortunate to have this specific genetic trait and given the right environment, it just happened”
Peer Influence	Teased and bullied; no friends growing up and few friends now	Difficult to keep relationships together when disordered; was able to create a supportive network; wife very supportive	Relationships tend to be motivating factors to diet	Growing up he was pretty much alone; food was companion. Has developed a friend network and OA sponsor	Negative impact for being overweight in both the U.S. (teased) and Bolivia (privileged)	Influenced by male ideal body; sensed others’ negative assumptions about ED; kept ED “in a jar”; struggle with male relationships and socially networking
Media Influence	Easy access to food especially if you have money; fast food addictive	“insult to be fat”; compared body image to rock stars	Money gave greater access to food	Heavily influenced from TV viewing; Easy access to food especially if you have money; fast food addiction	Became self conscious about body image; sense of negative assumptions people have about eating disorders	Body image and dieting messages taken literally and “overdid everything”

Table 2. Participant’s meaning making quotes and etiology themes drawn from the participants’ interviews (Continued)

	Scott	Jay	Casey	Michael	Chris	Edward
Cultural Influence	Stigma of being overweight Promotion of food addictions	Awareness of overweight stigma	Stigma of being overweight	Stigma of being overweight; rewarded for unhealthy eating; Promotion of food addictions	Stigma of being overweight and a man w/ED	Stigma of being a man w/ED; Stigma of having an ED; Rewarded for healthy eating
Trauma-related influence	Dad murdered; major car accident; repeated 2 school years; bullied			Raised in unstructured, turbulent environment	Teased for being overweight in the US; “privileged” in Bolivia	Sexually abused at age 10
Physical/Body Awareness	No treatment until hospitalized for low oxygen levels	No treatment until hospitalized; treated for anxiety	Sought treatment following doctor’s warning	Sought treatment; still experienced surgery to remove gall bladder	No treatment until hospitalized	No treatment for ED after first hospitalization; second hospital visit, treated
Personality Traits	Loner, Passive Hypersensitive High Neurotic Undisciplined/Low conscientious-ness	Introverted, Passive Hypersensitive High Neurotic Disciplined	Loner, Passive Hypersensitive High Neurotic Disciplined	Loner, Passive Hypersensitive High Neurotic Undisciplined/Low conscientious-ness	Introverted, Passive Hypersensitive High Neurotic Disciplined	Loner, Introverted, Passive Hypersensitive High Neurotic Disciplined Gender Identity questioning

The common themes impacting self-regulation processes and behavior among these participants included:

Family/genetic influences.

- Eating disturbances began in childhood. Participants linked with obesity modeled eating patterns established in their family of origin. Interviewees diagnosed with anorexia nervosa did not adapt to family norms.
- Participants seemed to have strong family bonds as all suggested feeling supported by their family of origin.
- A genetic influence was discussed by some of the participants. Scott and Michael shared family histories of being overweight and obese. Chris discussed that his maternal female cousins had an eating disorder. Edward stated, “Unfortunate to have this specific genetic trait and given the right environment, it just happened.” Jay believed his eating disorder was a physiological reaction deriving from puberty, “I think I was just wired that way” and Casey also said, “It just happened.”

Peer influence.

- All participants related some narrative reflecting peer relationship struggles. In some cases, individuals were teased and bullied; in other cases, the symptoms of the disorder prevented mutual bonds to develop. In one case, food was described as the individual’s companion. I interpreted these experiences as having a sense of belonging (or not belonging) to a larger population/society outside of immediate family.

- Reward/positive reinforcement seemed to keep individuals in their eating disorder. For Chris, he was admired (rewarded) for being overweight in Bolivia and admonished for being overweight in America. When he started to lose weight, his American peers rewarded him by way of compliments.

Media influence.

- Michael specifically mentioned the effect watching television advertising had on what he described as now having a food addiction. He stated, “It brainwashes you.”
- Jay shared that he had an awareness of body image as depicted by the media, but did not believe that this influenced eating behaviors.
- Interviewees being treated for obesity recognized that their access to money gave greater access to food. Extra income combined with a sedentary lifestyle and processed foods added body weight; for example, Casey disclosed, “I think my biggest challenge came after I got out of school when all of a sudden I had more money and I was working and I had money to buy what I wanted to eat.” He explained that he didn’t recognize the extent of the weight gain until it became unmanageable. Casey exclaimed, “wasn’t really noticing [weight gain] until I saw a picture of myself and went ‘wow’.”
- As an adolescent, Edward shared that he did take body image and dieting messages literally and “overdid everything.” He explained, that he would “swallow whole” (introject) messages about eating healthy and exercise

regularly to please others with such intensity, his already established eating disorder patterns from childhood were reinforced. His motivation switched from numbing out his body to wanting to take care of his body exemplifying assimilation of new knowledge into a pre-existing schema.

Cultural influence.

- All participants' responses seemed to raise a cultural awareness around the stigma of being overweight and/or an ideal thin/muscular physique. Jay said he was "aware that being fat was an insult" and Casey talked about wanting to "look more chiseled" when he was younger, but now sees weight as a health issue and relieved not to be seen as "the fat guy" in the room. Edward specifically mentioned wanting to acquire the ideal body image. Michael alluded to an awareness of a cultural stigma around weight as evidenced by his desire to lose weight to go to prom with a girl he liked.
- Chris and Edward spoke directly to the issue of being a man with an eating disorder and assumptions people have about the relationship between sexual orientation and eating disorders. Chris explained, "They might think that guys that experience [eating disorders] are more feminine or... they are totally obsessed with their image." And Edward expressed how he "struggled with relationships... because of the perspectives [peers] have."
- Scott and Michael spoke about the ease and inexpensive choices fast food restaurants offer. Both disclosed that they initially used food for comfort, which "snowballed" into a food addiction.

- Michael felt rewarded for unhealthy eating because he was saving money purchasing fast food, while Edward felt rewarded for healthy eating, because it resulted in him being thin.

Trauma-related influence.

- Scott's dad was murdered. Eighteen months following his dad's death, Scott was in a major car accident. He never received counseling for either incident; twice he was held back from school; and not knowing how to express his feelings, he used food to subdue emotions.
- Michael came from a turbulent, unstructured environment in which he had to learn how to care for himself on his own.
- Chris was teased for being overweight in the U.S. while deemed "privileged" in Bolivia for the same body shape.
- Edward was sexually abused at age 10.

Physical/body awareness.

- Several participants seemed to be unaware of what was happening to their bodies or physical health until the disorder forced them into treatment. Scott made known that he was not mindful about his appearance or his eating behaviors. "When I walked into the emergency room... my oxygen level was in the 30s and 40s and I was still upright. I was surprised at that." It was also the first time he became aware of the urgency for the need to lose weight. Jay disclosed that he passed out in class and was taken to the hospital. While he was diagnosed with anxiety and having had a panic attack, he believed it was actually an episode of orthostasis. This was his

first recognition that he was not in a healthy physical or mental state. Casey's doctor "had been pestering" him to do something about his weight before he had to be hospitalized. Michael was surprised that even after a year of healthy dieting and exercising he needed to have his gall bladder removed. Chris remarked that he saw how thin he was from his reflection in a mirror but was so deep in his disorder, he could not stop his behaviors nor did he reach out for help. It wasn't until he went to the doctor for a check-up that he succumbed to his parents and doctor's orders that he needed to be hospitalized. Edward was also hospitalized: "I went to the emergency room... because I passed out..." but he was not diagnosed at that time with an eating disorder, so his behaviors continued until he was hospitalized a second time and that was when he started treatment. Further, several participants used the phrase, "it just happened" to explain the etiology of their eating disorder, further evidence of their body/physical well-being was out of their awareness.

Personality traits.

In each case, there appeared evidence of a weakened self-concept, which seemed to prevent the development and maintenance of healthy relationships with self and others.

- Each participant described a solitary lifestyle and seemed to lean more toward an introverted personality. Per report, Chris and Edward leaned toward being more introverted while Scott, Michael, and Casey all spoke to ways they preferred to be alone or felt isolated because of their body image. Jay told of feeling isolated and invisible when in his eating disorder.

- These six participants represented having a similar level of sensitivity but exhibited different ways of self-soothing. I noticed that each of these participants exhibited a level of sensitivity in which there appeared a tendency to become easily upset or hurt by environmental stimuli.
 - Scott and Edward responded to traumatic events experienced in childhood. Neither received counseling for those events and struggled to make sense of what happened. Scott turned to food for comfort, while Edward, misinterpreting messages about food, followed a strict diet regimen.
 - Scott and Chris spoke of being teased by their peers for their body shape. For Scott, this led to apathy and complacency, so he continued to seek comfort through food. Chris resolved his conflict around relationships by eating less.
 - Jay stated he was hypersensitive and this is further evidenced by his reaction to physiological changes in his body that spurred an eating disorder.
 - Casey's response seemed related to dullness and loneliness as he described a "tendency to watch TV and just kind of sit there and graze on junk food."
 - Michael shared that his home environment was anxiety provoking on several levels like the uncertainty of having food and the turbulent dynamics in his home of origin. Food was a source of great solace in calming his sensitivities.

- The interviewees shared personality characteristics that could be summed using one of the Big 5 Personality Factor (McCrae & John, 1992) content scales, neuroticism, which includes traits such as abnormally sensitive, obsessive and/or compulsive tendencies, tense, anxious or depressed characteristics. No personality assessments were administered to these participants; therefore, there is no way to know where each might score on the neuroticism scale. Based on each participant’s response to the interview questions, however, distinguishing traits seemed apparent.
 - Scott, Michael, and Casey all spoke of emotional eating and exhibiting symptoms associated with anxiety.
 - A characteristic of binge eating disorder is compulsive overeating, and while Michael was the only participant to be specifically diagnosed with binge eating disorder, Scott and Casey described similar descriptors of binge eating in that they had a tendency to overeat. Casey remarked, “It became slowly a bad pattern of nutrition and portion sizes. I think a lot of that is what it came down to and I just started to eat larger volumes of food at one sitting.”
 - Jay specified that he exhibited personality traits associated with individuals having an eating disorder including “highly ordered,. . . perfectionistic... hypersensitive.”
 - Chris exhibited his hypersensitivity through his reaction in using eating disorder behaviors in response to feeling alienated and

privileged in Bolivia in contrast to being teased in America for being overweight.

- Chris made it known that he experiences depressive symptoms in his disclosure that he had been taking anti-depressants since age 13. “I’ve gone off at some points... usually feel myself [when] I need to go back on them.”
- One significant difference between participants in this study diagnosed with anorexia and those with morbid obesity/compulsive eating was the level of discipline expressed. In Table 2, again I used a term from the Big 5 Personality Factors, conscientiousness, (McCrae & John, 1992) because the descriptors of this construct aided in summing a common theme that emerged from these six participants’ interviews. In general, a conscientious person has a strong desire to perform well and demonstrate self-disciplined and organized traits (McCrae & John, 1992). On the other end of the spectrum, individuals exhibit a more carefree attitude often presenting as careless and impulsive (McCrae & John, 1992). Personality traits such as being less conscientious are associated with being at risk toward obesity (Bogg & Roberts, 2004; Jokela et al., 2013; Magee & Heaven, 2011). In this study, I noticed those participants diagnosed with anorexia tended to have a high level of self-discipline and determination while participants diagnosed with obesity or binge-eating disorder appeared to struggle with impulse-control and motivation. Chris, diagnosed with anorexia, said he made a decision regarding how much

food was enough and exhibited strong control. Also diagnosed with anorexia, Jay and Edward disclosed their ability to restrict and engage in demanding sport. For Jay, cross country running and for Edward, drill team. On the other end of the spectrum, Casey was in the habit of eating larger portion sizes and said, “it didn’t faze me at all.” Scott and Michael exhibited the challenges of emotional eating and not being able to exercise self-control. Since having bariatric surgery, Casey is experiencing a reverse effect in which he details, “I don’t have a physical striving for food, so therefore, when I’m busy, I don’t eat. Kind of like the exact opposite, you know, whereas before I’d go, I’m hungry, and you know go to the snack machine or whatever and sit there and pump junk food into me. Now, I’m busy and I don’t eat. And now it’s like, it’s 1:00 in the afternoon, I never did eat breakfast.”

A review of the common themes that emerged from questions regarding the eating disorder etiology for the participants of this dissertation follows.

Etiology common themes review. The data demonstrated that for each individual there was a variety of factors for the etiology of an eating disorder. From a Gestalt figure/ground perspective, each interviewee spoke of one specific factor that was really impactful to the development of an eating disorder. For Scott, that would be his dad’s death. Jay believed he “was just wired that way.” Casey “didn’t notice” how much weight he had gained “until I saw a picture of myself.” Michael was never introduced to a healthy nutritional diet and grew up without food restrictions or boundaries. Chris had mixed feelings from being teased in America for his weight and being favored in Bolivia

for being overweight. Chris shared, “when you are a teenager, that’s like kind of a hard thing [have a voice]. So I think I tried to work around it. At some point... an outlet seems kind of nice.” Edward was sexually abused.

With regard to disordered eating, participants either engaged in emotional eating or restrictive dieting in response to their circumstance. One encounter each participant described was a sense of being isolated and the varying ways interviewees coped with feeling lonely and alienated. Participants’ shared that they had minimal contact with others either by choice or because they had a sense that they were not accepted by their peers. I was struck by the idea of a sense of belonging and the need for supportive relationships, which seemed to be lacking for each of these participants. I heard six different stories of how connection with others (or disconnection from others) influenced a negative coping strategy for making or breaking contact in their social environments. Participants struggled with relating to others and seemed to use food (or deprive self from food and exercise excessively) to subdue anxious and/or depressed emotional states.

From the various participant narratives, I examined the broad range of responses to the research question, “how do you make sense of having an eating disorder?” One comprehensive theme came to mind: a sense of not belonging. There were repeated phrases, words, and expressed ideas that seemed to shout out “not seen,” “not heard,” “invisible,” or “I don’t exist” by each of these participants. These short excerpts offer evidence of a sense these participants revealed of not being seen or heard or belonging.

Scott relayed that he had been bullied throughout his school years. He described his life as if he had no relationship with people outside of his family: “I never went out, never had any friends, it was home, work, school. That was basically what it was.” He

told of a time when he went to a salvage yard to be weighed. He said, “That was so humiliating... it probably made me go deeper... like I... gave up.” He spoke of his struggle in finding his voice while he attended nursing school:

I remember [another student] telling me there were several instructors [that said] he’s not going to make it, there’s no way he’s going to graduate. And I did it... I mean you want to talk about HIPPA and other things in nursing... an instructor or professor should not be talking about another student to another student, you know, and here you are teaching the rules and the laws of nursing and here you are breaking it. You know, now, if that would have happened now, I probably would have confronted that professor.

Scott put into words ways he hides from himself; for instance, he stated: “I hate looking at myself. I hate seeing pictures of myself.”

For Jay, the “experience was that I didn’t exist... The disease didn’t exist. I was as a person with the illness totally invisible. And that, it was weird, it was really weird... how strange this is that this is happening and no one notices or seems to care... peers were silent.” As Jay moved from high school into college, this feeling of being invisible continued. Jay disclosed his experience while in medical school “was as invalidating as you can possibly imagine.”

Casey described periods of being alone in his youth. “I was typically at home on my own in the afternoon, after school, and so, I would have a tendency to watch TV and just kind of sit there and graze on junk food.” This pattern seemed to continue through adulthood as he later explained his habits living on his own. Per his report, Casey would

come home to an empty house and continuing the habit established in his youth, consume greater quantities of foods relatively devoid of nutrition. “When my marriage was kind of on the rocks and deteriorating... it became, I don’t need to worry about my weight for my wife’s sake because we’re... on our way out... I didn’t care.” I also wondered if he missed the signs of depression and if his message of “I didn’t care,” wasn’t an expression of feeling hurt, unheard, and isolated. He used food to comfort his feelings, which he acknowledged in his narrative.

Michael stated: “One of my defects is I don’t speak up for myself and people tend to walk all over me.” After 22 years attending Overeaters Anonymous, he exclaimed, “nobody is willing to sponsor me.” He also shared that except for his mother, he doesn’t get much family support. Michael shared that his home environment growing up was anxiety provoking on several levels like the uncertainty of having food and the turbulent family dynamics. Food was a source of great solace in calming his sensitivities.

Chris shared two separate experiences, both leaving him feeling alienated and alone. His peers teased him for being overweight in America, leaving him feel rejected. While in Bolivia with his parents, Chris stated that he didn’t know the language and experienced difficulty connecting with people. “Really, I felt kind of alone.” When he returned to the states, he adjusted by “escape from other troubles or things you don’t want to have to think about or deal with” using eating disorder behaviors. During treatment, Chris gave an account of the nursing approach in one facility left him feeling unheard and unseen. “I think they could have done a better job, and like, I’m dissatisfied in the way they treated me.” Later in his report, he disclosed his continued struggle in “being social or of trying to feel included or being listened to, yeah, there’s still some of that.”

Edward experienced a heavy judgment by his family and peers when he told them he was diagnosed with an eating disorder. Because of this, he came to understand that having an eating disorder is not something he could share. He used expressions “I should be quarantined” and the situation should be kept “it in a jar.” He described himself at the earlier stages of having an eating disorder as “not being a person.”

Etiology summary. In sum, etiological themes included several factors working in concert including a genetic proclivity, personality traits, weakened self-concept, and an environmental trigger that precipitated the eating disorder. In the larger picture, the essence of having an eating disorder was metaphorically related to a sense of invisibility.

The next section is in response to the portion of the research question about eating disorder treatment. Specifically, the following paragraphs address negative aspects of treatment, relapse, therapeutic alliance and therapeutic tools.

Treatment. Men may be reluctant to seek treatment for eating disorders (Costin, 2007; Freeman, 2005), so it was important to ask each participant about their treatment experiences. For each participant, an emergency or serious situation prompted treatment. Each participant expressed a moment that they felt like their eating disorder was out of their control and had a life of its own. As Chris poignantly stated, “I wanted it to stop, but I didn’t know how.” It seemed that it was at that moment that individuals sought treatment. Five of the participants were hospitalized directly related to symptoms caused by an eating disorder, and one was constantly pestered by his doctor to take action before he reached a point where he would have to be hospitalized.

Table 3 identifies the type of treatment each participant underwent and the themes drawn from the research questions pertaining to the treatment of an eating disorder. The themes comprise of the negative aspects of treatment, relapse, therapeutic alliance and therapeutic tools.

Table 3.

Treatment type and themes drawn from the participants' interviews.

Treatment Themes	Scott	Jay	Casey	Michael	Chris	Edward
Treatment Approach(es)	Diet & Exercise Lap Band Surgery	Organically re-fed; Developed social network	Gastric Sleeve Surgery, Group Therapy, Strict diet rules to follow	Group Therapy, Individual Therapy, Food Plan/Nutrition Therapy, OA, Spiritual practice	Re-feeding, Group Therapy, Individual Therapy, Nutrition Therapy	Re-feeding, Group Therapy, Individual Therapy, Nutrition Therapy
Negative Aspects of Treatment	Felt bullied at first nursing home; Self-Determined Diet & Exercise Plan; Lap band surgery did not meet his expectations	Never diagnosed, felt invisible/did not exist, disease did not exist; peers never commented	Medical anxiety; problems with inflammation following surgery	At age 19, no instructions or support following liquid diet; following relapse in 2011, trouble getting help/therapists appeared incompetent	Initial treatment stage watched/ not trusted; dissatisfaction in the way he was treated by nursing staff	Frustration in not being diagnosed or treated earlier; sensed medical professionals didn't know what they were doing initially; being watched & reported on by other patients
Relapse		At least once	At least four times	At least three times	At least once	At least two times
Therapeutic Alliance	"Staff is wonderful"		Strong alliance with doctors	Strong alliance with therapists (1991-2007, 2013)	Strong alliance	Strong alliance
Therapeutic Tools	Had Lap Band surgery; wants the full bypass surgery		Gastric Sleeve Surgery	Food Plan		ERP

Negative aspects of treatment. In general, people will take the path of least resistance, which is why breaking habits is so challenging. “Resistance or reluctance can be seen to operate only when the client has to accept a ‘truth’ externally imposed on him” (Clarkson, 2004, p. 106). In treatment, providers miss an opportunity to work with the resistance by exerting too much control. Chris explained, “it’s bad because you go in and you are already put into a box of what people say what people with eating disorders is like . . . I think I needed to be watched but it could have been done in a better way.” This approach can leave the patient feeling insignificant and invisible, exacerbating negative emotions and reinforcing low self-esteem. Michael Krasnow’s (1996) autobiography shared a similar sentiment:

I was admitted to... a psychiatric hospital... I was assigned to Dr. B. He was now the boss... I still refused to have anything but water. My vital signs became very bad... After four days... I was given the following option: ...I could have 500 calories, or I could be sent to a medical hospital to be force-fed. I ate that morning. I really tried. However, I had only about 400 calories, and I was discharged with instruction that I should be taken to a medical facility ...to this day, I don’t know why Dr. B was not satisfied. Perhaps he wanted to impress upon me that he was in control... I don’t know, but I think he could have been a bit more flexible. Sure, I had not consumed the required amount, but I had tried. I mean, come on.” (p. 13)

Treatment providers could be more supportive of the patients’ struggles to let go of the controls. For instance, for the anorexic, re-feeding is imperative, but as Chris

suggested, “I think they could have done a better job and like, I’m dissatisfied in the way they treated me.”

I was struck by the importance of relationship in connection with treatment. With regard to relationship, participants shared varying disturbances in contact with others undermining treatment. Several instances can be found in each participant’s narrative:

- Scott had to leave a nursing home facility because another resident was bullying him and staff was not able to find an agreeable resolution.
- Jay’s experience was that the disorder didn’t exist. He didn’t exist.
- Casey had problems with inflammation following surgery. He attempted to talk with nurses about his discomfort due to the fluids not passing through his system as predicted. He “freaked out” worried he would have to go back in for another surgery. “I really tried to go out of my way to not be a pain in the ass to [the nursing staff] ...I have to be gracious about the caregivers that I have... despite the fact that I’m in discomfort.”
- Michael spoke of success in losing weight following a liquid diet, but relapsed due to a lack of support. “I lost all this weight. But when they stopped giving the, um, you know liquid meals, I really didn’t know how to eat.” In August 2011, “I think I might have went to see a therapist or two, but they didn’t know what the [sic] they were doing.” This further frustrated his efforts to recover. It wasn’t until 2012, a year later that he realized that he had access to a food plan that worked for him previously.
- Chris spoke of the dissatisfaction with initial treatment in not feeling heard, trusted, or respected.

- Edward shared the frustration in not being diagnosed or treated earlier. At age 16, early on in treatment, he sensed that his practitioners were incompetent. “I did some therapy appointments once a week and went absolutely nowhere in recovery.” While in college, he was hospitalized for auditory hallucinations. Upon release from the hospital, Edward was admitted to a treatment center with a designated wing for males. He recounted the vigilante antics of other residents: “I was one of the only guys at that time who admitted to purging. I was still struggling with that in treatment but I would always tell staff when I did it. But some of the other guys would go into the bathroom and find stuff... these 2 or 3 guys were, of course, looking out for my best health, but they were very aggressive about thinking I needed to come out and say I’m purging.”

As treatment progressed, all shared that a major attribute in promoting their recovery involved a supporting connection with a significant other, such as a therapist, family member, friend, or life partner. Regardless of type of treatment, my conclusion from the interviewees’ responses was that they valued the support from others.

Relapse. The common factor regarding treatment seemed to be the number of times individuals relapsed, but still tried to change negative dieting behaviors either by re-entering treatment or implementing strategies that worked in the past. Casey shared that he gained and lost 100 pounds four times throughout his adult life, but that did not include all of the other times he went up and down the scale managing his weight through diet and exercise. From 1991 to 2007, Michael remained “abstinent... I didn’t have an extra bite of food in those 16 years and I stayed abstinent, or whatever you want to call it,

stayed on the food plan” and when he was put on medication for major depression, he relapsed. He relapsed again when a woman befriended him and then rejected him. At the time of the interview, he feared he might relapse knowing his mother had brain cancer and her recovery was not expected.

Relapse is a common occurrence during the recovery process with the rates noted in the literature review as between 35% and 60% for anorexia nervosa (Strober, Freeman, & Morell, 1997) and 70-90% for obesity (Stubbs & Lavin, 2013). Some theorists believe that individuals with ongoing self-concept disturbances are more likely to relapse (Bruch, 1973, Stein, 1996). Often times, individuals are released from treatment because their weight is restored and eating disorder symptoms are not evident. This “imposter phenomenon” is demonstrative of physical health being restored, but psychological recovery has not been achieved giving rise to the likelihood of a relapse. Edward’s story served as an example of this phenomenon. He went through treatment, following the prescription so that he could be released from treatment “to get back to college so I can do behaviors again.”

In general, relapse is a problem for all types of behavioral changes; perhaps a weakened self-concept is at the core of setbacks. Participants in this research expressed their thoughts that maintaining a healthy weight will be a life-long commitment.

Therapeutic alliance. Throughout each interview, I collected evidence regarding the importance of the therapeutic alliance and the impact that relationship has had on each participant’s recovery. Regardless of theoretical background, Norcross and Lambert (2011) stated that the common factors, such as the therapeutic alliance and the efforts of the clients, have the greatest influence on outcomes. As an example, Chris spoke

appreciatively of his therapist saying, “She didn’t make me feel trapped into a box or that I was just another person on her list of people to speak with” and Edward emphasized how his therapist “absolutely made recovery fun. She made it, not a game, but something, she taught me a lot about life through just her personality.” Edward went on to share, “as a kid, especially early adult in college and what not, you know, [I] have the mindset my parents have me in treatment... not the best mindset to have to really work on yourself, because it’s almost like I don’t want to do what my parents say, you know, like any teenager really thinks, but [therapist] really made it about improving my life and helping me to see that’s what it is all about.”

These responses of the participants in this study demonstrated that a patient’s willingness makes a difference in treatment outcomes. Participants described circumstances in which initial attempts failed, perhaps because they were not ready to accept and trust the treatment. Bardone-Cone et al. (2010) contend that a weakened self-concept prevent true recovery as individuals lack confidence in their ability to affect change. Chris talked about how “bad” treatment was initially, but he also acknowledged “I think I needed to be watched.”

Therapeutic tools. Another common feature in treatment, for the participants in this study, seemed to be accessing a “tool” that could help change behaviors in addition to supportive, empathic relationships. The “tool” provided the extra strength in coping with the emotional and mental qualities, which often kept individuals trapped in their eating disorder.

Several participants mentioned needing a “tool” to foster behavioral changes, but it was through a strong alliance with a therapist or doctor, or a support system (friends,

family, work...) outside of therapy that encouraged individuals to get and use the “tool.” Case in point, Scott had lap band surgery but didn’t have the success with it that he would have liked. I noticed that Scott didn’t have a therapeutic bond with any of the hospital clinical staff, and he mentioned that he had not checked in with the surgeon in over a year. Alternatively, Casey was convinced by his laparoscopic surgeon that the surgery would help him to lose and maintain a healthy weight. Further, Casey developed a strong bond with the surgeon and sensed that the surgeon cared deeply about his well-being. He had been in continual contact with the surgeon as well as participating as a mentor for others preparing for the surgery. This may be indicative of a shift from a “bad me” schema to greater acceptance, compassion, and knowledge of self that resulted from supportive relationships. In some of these stories, participants continued to struggle with support with their therapeutic tools.

While several different “tools” were named, including bariatric surgery, re-feeding, ERP, CBT, DBT, etc., it was clear an instrument for navigating change was a necessary component in the eating disorder treatment process. Additionally, in all cases the behavioral change was focused on diet and exercise habits.

Treatment summary. In summary, both negative and positive aspects of treatment were discussed. From the negative aspects, an overarching theme emerged. Using a metaphorical description, I named this theme “in a box” because individuals seemed restricted by the manner in which treatment was implemented. For instance, Chris and Casey described situations in which nursing staff appeared more focused on tasks other than addressing patient’s individual needs. In other words, participants in this study felt treated like an object and victim to a one-size fits all routine. Chris also spoke

of therapy sessions where group facilitators appeared as if they didn't want to be there; "they are just trying to get their credit or their part of a rotation done." These negative aspects perpetuated the sense of "not being seen or heard" or a feeling of being invisible.

On the positive side, the therapeutic alliance and having a "tool" were common themes instilling hope for recovery. Scott exclaimed, "I want that other tool" in referring to a full bypass surgery. Casey stated, "I was actually enthused by the fact that the tool was going to give me the ability to not want to eat." Edward believed the "exposure response prevention is really the reason I am alive . . . because somebody literally worked with me to change my behavior and challenge my thoughts." On the road to recovery, participants expressed a sense of not being seen or heard during the initial treatment stage and transitioned to a place where they start to experience a sense of cared for, seen, heard, and understood.

The next section is in response to the portion of the research question about eating disorder recovery/maintenance. Specifically, the following paragraphs address negative and positive aspects of recovery.

Recovery/maintenance. The participants' stories relay the importance and responsibility mental health care providers have in seeing the whole person and going beyond treating symptoms. Each of these individuals came to have an eating disorder for different reasons, but experienced similar treatments, including group therapy, individual therapy, and nutrition psycho-educational therapy. It was when each participant reported feeling invisible or unheard that they became resistant to therapy.

Table 4 identifies the stage of recovery/maintenance participants were in at the time of the interview and the themes drawn from the research questions pertaining to the recovery/maintenance of an eating disorder. These themes comprise of the negative and positive aspects of recovery/maintenance.

Table 4.

Recovery/Maintenance stage of each participant and themes drawn from the participants' interviews.

Recovery/ Maintenance Stage	Scott	Jay	Casey	Michael	Chris	Edward
Stage of Recovery/ Maintenance at time of interview	Life Long Struggle	Massively Recovered	Maintenance/ Almost at goal	Partial Recovery – on food plan	Recovered	Partial Recovery – no major behaviors
Recovery Themes	Scott	Jay	Casey	Michael	Chris	Edward
Negative Aspects	Have to be vigilant about medical care and telling medical team what needs to be done	Staying vigilant in keeping medical team abreast of changes in activity	Reverse trigger exhibiting restrictive or not eating, skipping meals	Having to speak up for self to ensure support is available	Assumptions people have about men with eating disorders	Assumptions people have about men with eating disorders; Struggle with developing a social network
Positive Aspects	Needs a tool (e.g., gastric bypass surgery), diet and exercise, back to work, outside support/ relationship	Maintaining a healthy weight, Need for control lessened; ability to talk about it openly and help others; relationship	Maintaining a healthy weight; positive reinforcements; treatment for self, not for others, mentoring others; relationship	stay on food plan, exercise, manage emotions, staying in relationship (therapist, OA sponsor) for account-ability and support	Greater awareness and acceptance of self, relationship/ supportive therapist and family	Shift from treatment for others to treatment for self, acceptance; importance of developing a social network/relationship

Negative aspects. Scott and Jay made known the importance of being vigilant regarding health care. Michael reinforced this notion in stating the importance of speaking up to ensure the support needed is received.

- Chris and Edward spoke about the assumptions people have about men with eating disorders. Chris explained, “I never felt really weird being a guy in a center for eating disorders. I felt... more self-conscious about being a guy outside of that, you know.”

Positive aspects.

- A cognitive shift took place whereby participants of this study recognized the value in taking care of self in comparison to making behavioral changes for others. For example, Casey lost weight to please his partner; but losing weight for his own well-being has been more fulfilling. He said, “It’s about feeling good, feeling good about yourself.” Edward described his shift in thinking about recovery as “I really started recovery with the mindset of I’m recovering for my sister, I’m recovering for my parents and that gave me the footing, I guess, to start really working on myself and eventually that developed into the perspective of I need to recover for me as well.”

Therapists that took the time to listen and develop a therapeutic alliance with their clients were sincerely endorsed. Several participants asked if their care provider could be named in this dissertation because they made a great impact on the recovery process. Chris said, “She didn’t make me feel trapped into a box or that I was just another person on her list of people to speak with” and Edward shared, “she really made it about improving my life and helping me to see that’s what it is all about.”

These participants came to recognize their behaviors, how they made meaning of their behaviors, and the issues that promoted their behaviors, whether it was from trauma, learned eating habits, biological and/or personality traits. Through this recognition and greater awareness, individuals seemed to have made a shift in their eating disorder thinking and in changing their behaviors. In this way, each became an agent for change, which is a recognized personal ability to increase awareness of one's way of being in the world and thereby, increased ability in modifying behaviors.

One role of Gestalt therapy is to encourage the use of self as an instrument of change. This is often accomplished by way of understanding resistances; an increased awareness into the way resistances present and influence contact with self, others and the environment allows for greater potential in better managing or changing behaviors. Recognizing that individuals with an eating disorder exhibit low self-directedness and a strong ability to present as competent, treatment providers are challenged to accurately assess recovery. One study found that fully recovered individuals exhibited higher self-esteem and self-directedness in comparison to those partially recovered suggesting that a healthy "self-concept may be an integral part of full eating disorder recovery" (Bardone-Cone, Harney, Maldonado, Lawson, Robinson, Smith & Tosh, 2010, p. 822).

I interpreted the participants' eating disorders as contributing to a disconnection between mind and body, resulting in negative outcomes including physical and mental health problems. On the other end, the rehabilitation of the mind-body (and spirit) including restoring natural hunger cues, a greater sense of self, and a healthier outlook had an invigorating effect. Following treatment, the individuals participating in this study reported feeling better both mentally and physically including a greater awareness and

acceptance of self. Casey declared, “I can get up and look in the mirror, you know, and feel good about myself.”

In some cases, the resulting confidence in self had extended to a greater empathic response toward others. Chris mentioned that he believed “a place of empathy” occurred from treatment. Jay remarked that part of recovery was having the ability “to take my own self-knowledge and to be able to utilize it for the good of others.” Casey was interested in becoming a mentor for others preparing for bariatric surgery.

It appeared, in general, that these participants recognized they were in recovery based on the degree to which negative behaviors had dissipated and healthier behaviors had become more automatic. Regaining hunger signals and an ability to trust hunger cues without a lot of structure around eating is a positive sign toward recovery. Of these six participants, Chris seemed the most confident in having achieved that place of trust and I wonder if the early detection and early treatment had something to do with his state of confidence and trust. Jay also reported this experience, but after 12-15 years of the disorder.

Neuroimaging studies have helped explain the complexity of neural connections that drive appetite (Carnell, Gibson, Benson, Ochner, & Geliebter, 2012) and suggest that these neural pathways can be changed. But what is the timeline for the restoration of natural hunger cues? Tylka (2006) identified three defining attributes of intuitive eating. These include: 1) an ability to eat unconditionally desirable foods when hungry; 2) the eating response is directly related to a physical need, not an emotional or psychological need; and 3) an ability to trust in hunger and satiety cues in determining when to start and

stop eating. Goss and Allan (2012) explained that intuitive eating can occur 3-4 months after consistent practice; Chris shared that it took him about two years.

What does recovery look like? Jay spelled out specific factors that indicated he has “massively recovered:”

I had to absolutely have no behaviors... #1 was healthy weight, by healthy weight I mean strong enough to do the things I needed to do without fear that my weight would negatively impact me. I had to not have behaviors, I had to not restrict in particular. I could exercise as long as I made up for the calories I burned... I had to be able to eat. Those were the absolute prerequisites. After those, I had to be able to live with... the community, be with other people, do what they wanted to do, enjoy the things that they put out there and not have to have it be my way based on whatever craziness was going on inside my head. And then I think the ultimate measure of my own healing was my ability to have this conversation, to take my own self-knowledge and to be able to utilize it for the good of others and to accept the feedback from others about whether it was working or not.

Recovery/maintenance summary. Participants that described self as being recovered revealed that they have a greater awareness of their perceptions, cognitions, and reactions to the environment and with relation to others. Interviewees spoke of goals in attaining greater awareness of self and building relational supports. All participants shared recognition in the sense that becoming autonomous and aiming to establish a self-identity, improved self-esteem, and a healthy body image was a process that took time;

but in time, recovery was possible as evidenced by Jay and Chris. As Jay expressed, “I feel massively recovered, which is not to say I cannot recover more” as personal growth is an on-going journey.

Summary

In sum, the main research question of this dissertation was, “how do men make meaning of having an eating disorder from etiology to recovery.” The six men who participated in this dissertation research helped answer that question by telling their stories. In each case, there was not one single factor, but a myriad of characteristics that worked in concert. Chris described the challenge of making meaning in his statement, “When you are in the midst of it, you don’t understand why.”

Common themes in etiology were explored from several aspects were comprised of family/genetic influences, peer influence, media influence, cultural influence, trauma-related influence, physical/body awareness, and personality traits. Common themes in treatment were comprised of the negative aspects of treatment, relapse, therapeutic alliance and therapeutic tools. Common themes in recovery/maintenance included negative and positive aspects of recovery. Those participants in recovery expressed an ability to self-regulate by responding to hunger cues and physical needs. Chris also spoke of “knowing and also accepting . . . I think I’m better at knowing my limits and not feeling bad that those are my limits.”

A comprehensive theme that is discussed further in the next chapter is the continuum from feeling invisible at the development of an eating disorder to feeling seen in recovery. Figure 2 gives an interpretation of that continuum.

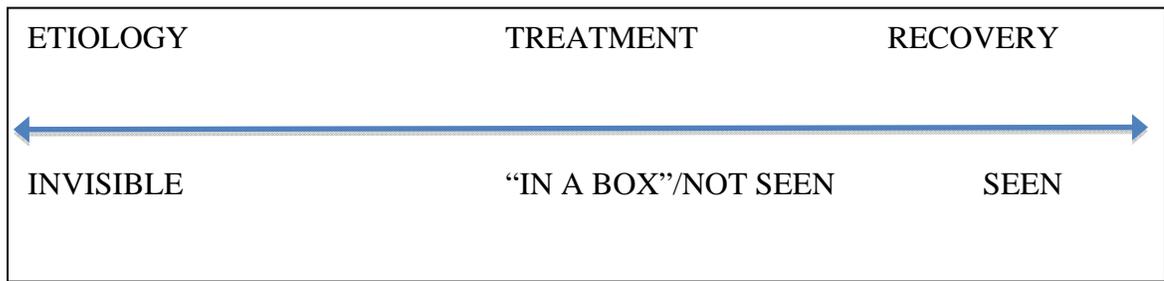


Figure 2. Continuum from feeling invisible at the development of an eating disorder to feeling seen in recovery

Chapter VI concludes this dissertation with a discussion of the findings and analyses, including suggestions for future research and implications for practice.

CHAPTER VI

DISCUSSION

Introduction

The main research question of this dissertation was, “how do men make meaning, from etiology to recovery, of their experience in having an eating disorder?” The six men who participated in this dissertation research helped answer that question by telling their stories. In each case, there was not one single factor but a myriad of characteristics that worked in concert.

Among the participants, several themes emerged from their stories. Research questions asked about etiology, treatment, and recovery/maintenance aspects of each participant’s eating disorder. The themes were drawn from interviewee’s responses and organized according to the stages (etiology, treatment, and recovery) of an eating disorder as defined in this dissertation. These themes are further explored in this chapter to discuss the extent that they are supported by the literature and theoretical conceptualizations reviewed earlier in this dissertation. These themes are discussed here in the order themes were presented in Chapter V.

Summary of Common Themes

Etiology. Family dynamics and diet values, ideas, and beliefs are influential in the way attitudes around food and body image are schematically organized (Smolak & Levine, 1994). Haworth-Hoepfner, S. (2000) explained four conditions found to be predictors of eating disorders for youth: 1) a critical family environment; 2) coercive parental control; 3) an unloving parent-child relationship; and 4) main conversations regarding weight or appearance. Interestingly, these factors were not shared by these six participants. In fact, interviewees suggested feeling supported by their families of origin. Some of the individuals suggested that there may be a genetic influence for their eating disorders, as Scott and Michael both shared about their family histories of obesity. For the most part, family influence did not emerge as a main factor for the origins of an eating disorder in this study. However, individuals linked with obesity modeled eating patterns established by their nuclear family.

Peer influence is often referred to as a contributing factor of eating disorders (Polivy & Herman, 2002). Individuals assimilate attitudes and behaviors of their peers, from which the influence may be through modeled actions, pressure, teasing, or bullying. Participants in this study indicated struggles with their peer relations. For example, Michael had a lot of difficulty finding a roommate and with feeling supported at OA meetings. In 2009, someone who befriended him, just “pulled away.” Michael felt so rejected, he relapsed soon after; on reflection, he commented, “You have the right to include people in your life and you have the right to keep them out of your life.”

According to Kearney-Cooke and Steichen-Asch (1990), individuals that were reportedly overweight were teased in school. Several participants in this dissertation

research shared that they were alone much of the time and that food filled the experience of emptiness. In some cases the disorder itself prevented strong peer relationships from developing; for instance, Scott reported he had no friends in school, and Jay shared that he had difficulty maintaining relationships. Additionally, positive reinforcement seemed to have kept individuals trapped in their eating disorders; for example, Chris shared he started receiving compliments for losing weight, which he found encouraging and continued restricting food intake. Overall, peer influence seemed to be a factor and triggered a sense of feeling invisible or not seen.

The plethora of research studying the relationship between the media and eating disorders is plentiful (AED, 2010; Klump, Burt, Spanos, McGue, Iacono, & Wade, 2010; Haworth-Hoeppe, 2000; Peterson, Paulson, & Williams, 2007; Polivy & Herman, 2002). The promotion of dieting and exercise is widely publicized through exposure to television, magazines, and internet access as well as other institutions that have a social and financial interest in the subject matter (e.g., the fashion industry) (Cafri, Yamamiya, Brannick, & Thompson, 2005b; Cusumano & Thompson, 1997; Goodman, 2005; Groesz, Levine, & Murnen, 2002; Harrison, 2001). The motivation to attain a thin or muscular ideal derives from a need to be socially accepted and to have a sense of belonging to the group. Family, peers and institutions often echo media messages. This, in turn, can promote the development of eating disorders (Hesse-Biber, Leavy, Quinn, & Zoino, 2006). Edward seemed to have been influenced by American cultural media as he disclosed taking body image and dieting messages literally. However, the other participants did not share a strong media influence as their motivations to diet and exercise. In fact, Michael vocalized an opposite effect in that he found television

advertising promoted food addiction and obesity. Considering the age range of these six participants, the media influence may not have been as great for the older interviewees in comparison to those coming of age in the 1990s during which significant changes in television advertising developed a greater focus on gender imagery. Today, the continuing development and growth in graphic representations of American cultural standards focusing on image is prevalent in all media forms including the Internet. However, several of these participants were relating the etiology of their eating disorder from a time period when a product being sold was the center of attention versus the model selling the product. This may explain why the media was not expressed as having a strong influence in the etiology of an eating disorder for some of these participants.

Cultural influences emerged corresponding with stigmas. Three issues were expressed. First, all participants acknowledged the stigma of being overweight. Second, having an eating disorder was stigmatized. As Edward explained, “I think I’ve seen it more as a disease probably to hide behind the social stigma of it because if it is a disease... than it should be more acceptable in society, but at the same time knowing that it is... a mental health condition.” Third, Chris and Edward spoke of the stigma of being a man with an eating disorder. Scott, Casey, and Michael spoke about the fast food culture and the fact that money gave them greater access to food. Scott and Michael were passionate in explaining how American culture promotes food addiction through the ease and availability of affordable food products are made available.

Some of the participants were influenced by trauma-related incidences, which they reported made an impact on using disordered eating behaviors to cope with negative stimuli. Strother et al. (2012) found that the relationship between eating disorders and

sexual abuse occurs in approximately one-third of patients. This seems to hold true in Edward's story, when he reported he was sexually abused at age 10.

Strother et al. (2012) wrote that an individual being bullied during childhood "may react to this trauma by conscious or unconscious manipulation of body shape" (p. 348). According to their study, men focused on becoming more muscular to better protect themselves against aggressive attacks. While Chris did react to being teased about his body shape, his goal was to become thinner, not more muscular. On the other end of the spectrum, Scott, an emotional eater who struggled regulating his eating behaviors, also reported being bullied throughout his school years. This had an effect on his level of confidence, yielding a poor self-concept. Michael's home life was reportedly turbulent and unstructured. He also used food to subdue negative feelings.

The Gestalt approach is a holistic perspective respecting the body-mind-spirit interconnectedness. For the eating disordered individual, the body has been avoided, desensitized. "To the extent people are alienated from their physical selves they will interpret sensations falsely" (Clarkson, 2004, p. 89). I was not surprised that a common theme among these study participants was their lack of body awareness. In each case, individuals were hospitalized or warned that they would have to be hospitalized for reasons directly related to negative eating behaviors.

In Polivy and Herman's (2002) literature review, personality characteristics and a weak identity formation were the most plausible factors in explaining eating disorder etiology. A negative self-image (Barlett et al., 2008; Smolak et al., 2005; Stein, 1996) forms through the meaning making and schema organization of the individual's field experience. My review of the literature discussed specific personality traits common to

individuals with an eating disorder. Bunnell (2010) listed perfectionistic qualities, obsessive-compulsive tendencies, low self-esteem, and poor interoceptive awareness. The participants in this study discussed these characteristics as well as anxiety and depression.

Interviewees identified with different aspects of self to explain their eating disorders. Scott's emotional self had no way to understand or express his feelings around the traumatic death of his father and in turn, he turned to food to relieve his anxiety and later, his loneliness. Jay's physical self was impaired, as he believed his eating disorder was a response to puberty. Casey spoke of a sedentary lifestyle, emotional eating, and a diminished value on body size; this related both to his physical and emotional aspects of self. Michael relieved negative emotions through eating and became addicted to food. In his recovery goals, he spoke of the importance of his emotional maturation and development of a healthier relationship with his spiritual self. Chris alluded to the cognitive aspects that affected his self-concept. Edward felt empty as a result of being abused, impacting his physical, mental, emotional, and spiritual sense of self.

From a Gestalt perspective, I am interested in how individuals responded to the immediacy of the initiating encounters from which a dominant contact style developed. In Gestalt language, their sense of self, their self-organization, was heavily influenced by introjected "shoulds" like "I should look... male ideal" (Edward), "stuff I shouldn't be eating" (Scott), or "I should be provided with the healthy food I need" (Michael). These are messages that "undermine a person's actual experience... even attack the essence of a person" (Yontef, 2005, p. 86) and inhibit self-regulation and a well-balanced personality.

In the final analysis of identifying the etiology of an eating disorder, all of the factors combined left me with an overall impression of these participants' experiences of

not being seen, feeling empty, and invisible. Jay was very direct in his expression of feeling invisible: “I was as a person with the illness totally invisible.” Others expressed this idea metaphorically, like Edward having to keep his diagnosis “in a jar” hidden away where no one will see or hear. Chris spoke of feeling alienated, which is a very isolating experience. Scott had no friends; his life sounded very solitary. After I read each transcript for etiology themes, I became aware of the introjected regulating behaviors.

Introjected regulation implies that a partial internalization of values and identities has occurred such that people apply intrapersonally that which had been applied interpersonally by socializing agents. In so doing, they experience rewards and punishment, typically in the form of self-esteem-related feelings and appraisals, and it is these contingent self-evaluations and their affective consequences that regulate their identity. (Ryan & Deci, 2012, p. 230)

Treatment. The initial stages of treatment presented challenges for all of the participants. In some cases, the motivation was not there. To further elucidate motivation, Edward reported that he went through treatment for three months with a plan to appear cooperative in order to be released. In his words, he said, “I can literally remember my mindset. My last day at [a treatment center] the first time, I was like [in] my mind, I need to get back to college so I can do behaviors again.” In a sense, Chris was mandated to treatment due to his young age. When asked about his motivation to enter treatment, he said, “It wasn’t really a choice.”

Per the participants’ accounts, health care professionals who treated them followed treatment protocols, without addressing the emotional impact of treatment. This

created added anxiety, resistance to treatment, and continued eating disorder disturbances. A common theme among the participants was experiencing a sense of indifference from the professional caretakers each was dependent upon during their initial treatment. Some of the participants also questioned the level of competence among health care professionals. Participants seemed to be conveying the disadvantages of standard practices; for that reason, I interpreted the overall essence of the treatment experience as “in a box” and again, this reinforces a sense of not being seen. Chris summed this up best in his comments about treatment being “bad because you go in and you are already put into a box of what people say what people with eating disorders is like, you know, or what their book says, or something like that.” Once individuals were matched with professionals or a treatment center that best fit their needs, the therapeutic alliance and treatment outcomes were much improved.

Recovery/maintenance. Of these six participants, only two met the criteria for being in recovery or maintenance at the time of the interviews for this current study. In spite of that, all six individuals were able to express what recovery would look like to each one of them personally. Those participants that were treated through an eating disorder treatment center reported recovery outcomes consistent with current research regarding recovery (Anderson, 1990; Berkman, Lohr, & Bulik, 2007; Costin, 2007). Jay’s recovery could be characterized as taking place organically; however, Jay demonstrated a strong vocabulary and understanding of recovery outcomes as discussed in the literature and in the field, and seemingly, reported recovery outcomes compatible with the three participants that underwent treatment at an eating disorder center. Casey’s treatment was by way of his internist and bariatric surgeon. His understanding of recovery is based on

his expectations of the gastric bypass surgery. Scott's situation is unique in that he is living in a bariatric nursing center, which assists Scott with conditions related to obesity, but does not actively offer treatment for obesity. He has undergone lap band surgery, but reports not being happy with the results. Scott had an understanding of his illness and potential for recovery based on his education and career background in nursing, and his willingness to attend classes on nutrition and participate in exercise programs offered by his place of residence. Each participant's story was unique, and each coped with life stressors by way of an eating disorder in a manner that seemed to conform to their self-concept.

In applying a self-schema model, individuals experienced an increased awareness of their personal nature giving rise to the potential of fully understanding "the who" and "the how" of one's being. In this study, interviewees exhibiting a greater sense of self seemed to be further along in the recovery process. Chris put into words how he came to understand his limits and to respect and honor his limitations. Jay detailed what it meant to be "massively recovered." Included in his list were measures beyond diet and exercise; "the ultimate measure of my own healing was my ability to have this conversation, to take my own self-knowledge and to be able to utilize it for the good of others and to accept the feedback from others about whether it was working or not."

This led to my conviction that additional interventions need to address self-discovery as part of treatment. If only symptoms are treated without an awareness of self-regulating behaviors and contact styles, the individual will relapse into their practiced way of being in the world. In turn, eating disorder research could broaden the focus to go

beyond the need of changing one's faulty beliefs about diet and image to include greater awareness of self-concept deviations.

From their responses to the interview questions, each participant's beliefs about self and about self in relation to others were revealed. For instance, individuals who reported gaining self-awareness improved their ability to eliminate negative behaviors and improve relationships with others. The themes that emerged highlighted how concept of self was used to order their lives around an eating disorder. For the participants in maintenance/recovery, a better outlook and more positive self-concept was related to restored health.

The literature (Bardone-Cone et al, 2010; Koskina & Giovazolias, 2010; Stein, 1996) demonstrated that eating disorders are often associated with negative beliefs about self, which can impede healthy identity development and can manifest insecure attachment patterns. This study testified to the manner in which relatively normal functioning became disrupted due to environmental concerns along with the underlying dysfunctional mental processes that contributed to the development of the eating disorder. Further, this research discovered how contact styles, which participants initially developed to cope with a situation, can become problematic and fixed. Identifying individual self-regulating patterns offered greater understanding into the individual's way of being in the world.

A Comprehensive Theme

In analyzing the findings of this dissertation study, I noticed a pattern of participants feeling invisible during the early development of their eating disorders, through the beginning of treatment that slowly blossomed into wanting to be seen. Full

recovery seemed noticeable in Jay's acknowledgement of having a "way to take my own self-knowledge and to be able to utilize it for the good of others." At the time of the interview, Casey was involved in mentoring. He recounted that hearing testimonials from others regarding bariatric surgery was influential in his making a decision to have the procedure. Casey inquired from his surgeon about participating in the mentoring program. He appeared enthusiastic as he reported "I've had one guy who was going in for surgery call me and I spent like 30 minutes with him on the phone." He also mentioned another individual who was having surgery around the time of the interview whom he planned to visit in the hospital. Casey shared, "he hasn't invited me, but I know on Thursday is the day he should be recovered enough, I'm just going to see him to encourage him." He role-played what he planned to say when he arrived at this man's hospital bedside unannounced, "You know what, I had someone walking in the room at this stage, and I just want to congratulate you on what you've done and encourage you on the path ahead."

Chris was interested in advocating for better perceptions of individuals with an eating disorder as evidenced by his question, "Do you mind if I go into a story?" during the interview. Subsequently, he shared an account demonstrating the negative assumptions people make about individuals diagnosed with eating disorders. The full narrative was reported in Chapter IV, and, I imagine, he hoped this testimony would be published in this dissertation to highlight "the complexity of it all... how for people it is a proxy of what they are thinking about, when in fact, it is much more."

When participants spoke of their initial eating disorder stages, they shared stories of being alone, feeling alienated, and struggling with peer relations. Jay specifically

stated that he felt invisible. This sensation continued during the initial treatment experience. At the other end of the continuum, in recovery, these participants spoke of relationship and support along with an interest to capitalize on their newfound sense of wellness by reaching out to others.

Participants in this study discussed that the treatment experience was challenging, and as several participants shared, the treatment staff did not do much to ease their anxieties. Scott was bullied at his first nursing care facility, and from his perspective, the staff members had no empathy for his situation. Jay stated, “How strange this is happening and no one notices or seems to care.” Casey spoke of the concerns he had following surgery and tried to get the attention of the nurses. Per his account, they turned a deaf ear and went on about their work tasks. Chris, at the age of 13 or 14, recounted that the nurses were mean, and he believed “nobody is going to listen to you.” However, Casey was in his late forties when he had surgery. Apparently, age, in these cases, did not seem to make a difference in being seen and attended to as a person.

Edward shared disappointment that he wasn’t diagnosed the first time he was hospitalized and had the impression that medical staff was incompetent. These negative initial experiences left these individuals feeling not seen and not heard. This may be a point when many individuals leave treatment early, which was the case for Michael Krasnow (1996). Other stories of early treatment experiences -- being in group therapy with facilitators who appeared as if they did not want to be there, or nurses that did not have time to offer an empathic response – furthered these participants’ sense of being alone, unseen and unheard. Interviewees described a cookie-cutter approach to treatment.

While the prescription of re-feeding and nutrition psychoeducation may be “right,” participants reported that it felt “in a box.”

In contrast, recovery was experienced by the participants as being seen. Chris stated his individual therapist “didn’t make me feel trapped into a box or that I was just another person on her list of people to speak with.” This was a complete turnaround from his initial treatment experience, and for the first time, he felt heard. Further, Chris breathed a sigh of relief as he disclosed that for the past five or six years “I am able to follow my body cues and my hunger cues and you know, I’m just so happy I got to that point.” Jay spoke of rich relationships; this is quite the opposite from his statement of not being able to keep relationships together while in his disorder. Casey shared how good it felt to not be looked at “as the fat guy in the room.” When I heard their stories of recovery, their faces were lit up and their eyes bright. I felt their excitement, and I remember thinking I know this feeling. It is a feeling of being seen, accepted, a part of something larger than self. Casey spoke of his new feeling of confidence. Edward spoke of how good it felt to work with a practitioner who understood him and allowed him to “float down the river” happy and free.

Limitations

While I cannot generalize these findings into the general male population, the stories of these six participants contributes to the literature in understanding how men experience acquiring an eating disorder, the treatment process, and the recovery experience. Sample size is a common limitation with qualitative study; this is the trade-off between quantity and quality. The data collected through this research is rich with information; however, the relationship between identity, body image, and/or self-esteem

disturbances and the emergence of an eating disorder can only be discussed to the extent experienced by these participants. Future studies should seek to recruit larger samples.

Another limitation of this study included a lack of minority representation. All of the interviewees were Caucasian, although from different religious upbringings. Participants represented a large age range, from 21-60 years old. They also represented a broad range of eating disorder diagnoses, including anorexia nervosa and morbid obesity. Because my theoretical orientation focuses on one's self concept, I interpreted the extremes being presented as representations of different personality types and worldviews. For instance, Jay and Casey both came from families that were abundant in food sources; yet, Jay restricted and Casey overate. Individual temperaments and beliefs are necessary to fully grasp the essence of an individual's total experience.

Several factors made finding participants for this study difficult. First, and probably most influential, is the general consensus that men are reluctant to come forward. However, I was fortunate that these six men wanted to have their stories made known for the benefit of others. Perhaps, their initial sense of feeling invisible and the shift to being seen explains their motivation in participating in eating disorder research. Another reason for the great underrepresentation of men in eating disorder research may also be due to the possible triggering effects when talking about one's eating disorder. I limited my recruitment efforts to treatment facilities and providers in my desire to ensure participants were stable and able to talk about their experiences. This also ensured that participants had an established relationship with a therapist for follow-up if they were triggered.

Other impeding factors included time, weather, and money. Time restraints prevented me from continuing my recruitment efforts, as I wanted to meet a reasonable deadline for completing my study. The winter weather prevented me from travel to meet with potential participants. Last, but not least, I lacked the funding to promote my efforts through paid advertising or to offer participants any incentives. On this latter note, I am glad that these participants were willing to talk about their experiences for the purpose of improving efforts in the diagnosis and treatment of eating disorders for men.

The focus of this study was very broad and attempted to analyze the entire eating disorder cycle from etiology to recovery regardless of diagnosis. I intentionally designed this research to be all-inclusive of males with any eating disorder, because I wanted to learn about what factors encouraged these men to seek treatment, what challenges they faced that led them to recovery, and what fostered recovery. Additionally, I wanted to learn how individuals know they have recovered or what they imagined recovery could look like. In hindsight, each one of those questions could have been a separate study and could have been broken down further by eating disorder type. Future designs might consider a focus on particular aspects of treatment specific to eating disorder diagnoses as it pertains to men.

This study defined eating disorders based on the DSM-IV-TR guidelines. The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5; American Psychiatric Association, 2013) was published in the midst of the writing of this dissertation. The definitions for eating disorders have been revised to improve diagnostic measures, but remain insufficient in diagnosing obesity. Obesity is not included even

though the evidence supporting the notion that behaviors associated with obesity are consistent with addictive and eating disorder characteristics.

Future Research

According to the DSM-IV-TR, the diagnostic criterion for eating disorders is primarily focused on women. Future research and advocacy efforts are necessary to better address males suffering with an eating disorder. Assumptions that eating disorders are a female or gay disease need to be disputed to relay the reality that eating disorders are nondiscriminatory. It is necessary to create a safe path for men to seek treatment.

With the advent of multidisciplinary teams and mandated managed care policies, manualized treatments have increasingly become the norm. On paper, it may appear that manualized treatments have the potential to increase service coverage and promote best practices for the treatment of eating disorders, but the impact on the individual seeking treatment is often disconcerting. As Jay and Chris stated, the sense of being invisible intensified during the initial stages of treatment. Further, prescribed practices may have been the ultimate reason why Michael Krasnow (1996) refused treatment; he, too, reported that he didn't feel seen or heard. His opinions were insignificant in comparison to the important task of fixing the problem by way of following the manual. Ultimately, the grave downside to manualized treatment is a cookie-cutter approach stemming from an assumption that one size fits all. This prevents the practitioner from meeting the individual needs of the patient; instead, mental health providers are meeting the requirements of managed care.

As evidenced in these participants' stories and Krasnow's (1996) story, following treatment protocol can often threaten the psychotherapeutic relationship and prevent the

patient from becoming wholly healthy, since only the symptoms of the behaviors are treated. Rogers (1951) theorized that the more aware and accepting an individual is about all parts of self, the clearer, integrated, and actualized is one's self perception. When an individual is able to see self as a perceiving, organizing agent, rather than as one governed by external factors, then that individual has greater potential to control and own behavior, thereby, progressing personal development. While effective treatment strategies are important to note, they should not be imposed at the expense of the psychotherapeutic relationship. Research efforts might explore finding the balance between effective interventions and the client-therapist relationship.

According to Stein (1996), "For more than three decades, investigators from diverse orientations have argued that the person's attitudes, beliefs, and thoughts about the self are critical in understanding the disorders" (p. 106). From this study, I am better informed of the way contact styles and the prevailing coping strategies were pervasive in the etiology, treatment, and recovery aspects of six individuals diagnosed with eating disorders. In this study, invisibility was a theme that each participant experienced as the disorder took hold and was sensed through the early stages of treatment. The understanding and treatment of eating disorders would benefit from further research in ways contact style and eating disorder behavior relate and in turn, drive a sense of being invisible. Future studies might include a quantitative measure of "invisibility." One way this might be accomplished is by way of using Morey's (2007) construct for "nonsupport" researched for the Personality Assessment Inventory (PAI; Morey, 2007). Through this suggested research, practitioners, caregivers, and patients will have another measure of their well-being, greater awareness into the way in which the individual

breaks contact with other, and learn of coping strategies to better regulate contact and prevent a decline in mental health.

A longitudinal study may help address relapse concerns and better record if perspective shifts are representative of pseudo-recovery or actual recovery. Measures might include the degree in which an individual felt supported, sensed invisibility factors, thought processes affecting behavior, and experiences of a healthier self-concept. The study might also provide coping strategies individuals use to maintain or further improve upon self.

Jay's story inspired me to gain a better understanding of biological factors; however, I was not able to find much research on pubertal status and timing, endocrine abnormalities and neural disturbances with regard to males. Research efforts in this area would promote awareness and prevention measures. Further, Jay shared the positive reinforcement experienced in attaining goals (e.g., evidence of weight loss on the scale) and from the physiological effects of fasting. Explorations of the intrinsic factors that keep individuals in their eating disorder could be further investigated.

In the future, further explorations of better options for the re-feeding process are needed. Re-feeding is a currently imposed first course of treatment for anorexia nervosa. It appears that a standardized procedure may be applied to all patients/clients, without considering the possible harm re-feeding too quickly might impose, as in Krasnow's (1996) case. I was struck by Krasnow's (1996) story and cannot understand the hurried, seemingly overwhelming delivery of calories. Jay was able to restore his weight through a natural approach and seemingly, more gentle, caring manner. My hope is that research

endeavors on this intervention would promote an empathic, organic manner to restore weight and health.

Implications for Practice

In each story, participants acknowledged the importance of a behavioral intervention necessary to lose or gain weight. However, they also mentioned the continued struggles in coping with life stressors, in particular regarding contact with others. I believe and respect that the first order of treatment, once an eating disorder is identified, has to involve regulating one's diet and maintaining a healthy nutritional food plan. Once an individual's weight is restored, cognitive behavioral interventions can address the importance of increasing one's ability to recognize environmental, social, and emotional triggers and can assist eating disorder patients in developing alternative ways for meeting emotional needs; however, these interventions fall short in addressing self-concept disturbances consistently affecting the relationship between personal and social identity. As treatment providers, we need to "be aware that we all limit our self concept through disowning certain human qualities. Notice how clients do this and support them to explore a wider range of emotional attitudes and behaviors so that they can respond more flexibly to the world around them" (Mackewn, 1997, p. 123). In turn, this could enhance the healing process and prevent relapse.

Gestalt theory offers a "cycle of experience" model that may be used to chronicle what transpired as a person attempts contact with self, another person or group of people, or with the environment. Using the Cycle of Experience and contact styles, intervention strategies could offer potential for healing not only the eating disorder, but also core issues.

First, in addressing participants' sense that they are not seen or heard when they first enter treatment, their feelings might be projected or transferred onto another; for example, the nurses become the parent figure for the patient. It may also be projection in the sense the participants were not able to own their experience so they blamed others for their experience. To illustrate projection, Edward was frustrated "that the education these physicians had was not comprehensive to cover" ways to treat an eating disorder. He went on further to explain that the first therapist he worked with "was never really treatment focused." He seemed to place blame on the medical and mental health professionals for not treating his eating disorder, but initially, he wasn't open to being treated as evidenced by his comment, "I would never say I was the one that wanted treatment. It was more of like my parents, um, really pushing me along to do that." So, it appeared that he was blaming others for not identifying his eating disorder while he was doing everything he could to hide it. In this way he was not holding himself accountable for his actions and projecting onto others the need to address this problem. While patients may be projecting, health professionals, even though overwhelmed with work schedules and duties, need to take a moment to validate the patient's experience. Practitioners must always be able to empathize with the patient while at the same time give treatment to individuals.

One way to consider this is from an I-Thou perspective. Buber (1970) explained that there are two ways to be in contact: I and It or I and Thou. When we are connecting with others from an I-It perspective, we are treating other as an object, pushing "it" around to suit one's needs and judging "it" based on stereotypes and assumptions. From an I-Thou stance, we are relating to one another by seeing and acknowledging the person.

Through this here and now experience, we connect compassionately and make contact in a mutually respectful manner. This, by itself, is immensely therapeutic.

Second, the issue of relapse can be very devastating. Michael, who has relapsed at least three times, believed that “managing your emotions... is key.” Treatment needs to go beyond addressing presenting symptoms. Therapeutic interventions ought to promote success in acquiring self-regulating functions, including emotional regulation, and maintaining a good level of self-esteem. Helping individuals gain awareness of their self-regulation processes, and an increased awareness about self, will increase their knowledge about self. “This means that the more fully I can become aware of who I am and what I am doing at this moment, the more freedom I can experience to change and the more I am able to choose my responses” (Clarkson, 2009, p. 15).

Conclusion

This closing thought on the importance of relationship is critical to the entire eating disorder cycle. Initially, participants reported a sense of discomfort with other people, which encouraged a break in contact from the environment or some aspect of self that moved each participant to develop an eating disorder. In Gestalt Theory, this would be termed a creative adjustment. In other words, individuals felt a need to adjust behaviors in order to survive in their current situations and found ways to adapt using the best resources available in the moment. Suffering ensued when the adjustment became fixed and new adaptations were difficult to acquire, often because the “fix” was outside of one’s awareness or had become compulsive. Treatment, regardless of theoretical orientation, was about becoming aware of thoughts and behaviors maintaining this fixed

state. Once awareness was realized through validation and meaning making, participants were more willing to explore and try on other possible ways of adapting.

Highly self-aware people are able to respond flexibly and variously to a broad spectrum of different people and situations. They recognize that they need a wide range of human qualities in order to make contact and deal with the complexities of the world in which they live. The more aware the person, the more qualities and apparently contradictory polarities they can accept within themselves and the more they can flexibly acknowledge many facets of their personality... Less aware, more disturbed people are less able to acknowledge a range of characteristics and have a much more limited, defensive view of themselves. They tend to be identified with some qualities and alienated from others. (Mackewn, 1997, p. 120-121)

Another important factor pointed out by these participants diagnosed with an eating disorder was the importance of being stabilized, both mentally and physically, before talk therapy could be effective. Tools used to stabilize individuals and to address habitual behaviors included bariatric surgery, nutritional training therapy, or intense re-feeding. Additionally, healing and recovery seemed to be overwhelmingly related to relationship as evidenced by the participants' responses regarding the therapeutic alliance and close bond they developed with a significant caregiver.

In the literature (Pettersen et al., 2011), eating disorder recovery rates seemed to be based on behavioral measures and did not take into account the power of relationship. Another way to frame this occurrence is the overwhelming emphasis on the medical

model approach and studies focusing on relational models seem harder to find. Anderson (1990) emphasized three main elements for treatment: (a) identifying specific themes depicting the core purpose an eating disorder serves in the patient's life; (b) using a mix of psychotherapeutic approaches including individual, group, and family therapy; (c) meeting the needs of the patient. This goes beyond treating the eating disorder symptoms and involves cognitive behavioral, psychodynamic, and existential methods. By furthering this research in understanding the interdependence between self-concept and eating disorders, treatment interventions like exploring the client's context and contact style, could assist individuals in developing an autonomous self in the context of dialogic relating rather than relating by coercion.

Last, but not least, my hope is that all men will be included in future research pertaining to eating disorders. Dr. Richard Morton was the first to publish a case study about a 16-year-old male with an eating disorder in 1689 (Silverman, 1990). Here we are, 325 years later, still with limited information about males with eating disorders. Efforts to continue making health care providers aware of the risks for eating disorders among all men is crucial to remove the stigma of eating disorders as being a female or gay disease and remove barriers for treatment.

I am glad that these participants were willing to talk about their experiences for the purpose of improving efforts in the diagnosis and treatment of eating disorders for men. In relating the stories of these six participants, my hope is that my interest in their accounts and my desire to write about their experiences contributed to their sense of being seen and heard. I have much gratitude to each of them for their contributions.

REFERENCES

- Academy for Eating Disorders. (2010). *Questions and answers on eating disorders*. Retrieved from http://www.aedweb.org/AM/Template.cfm?Section=Resources_for_the_Press&Template=/CM/ContentDisplay.cfm&ContentID=1890.
- Agliata, D., & Tantleff-Dunn, S. (2004). The impact of media exposure on males' body image. *Journal of Social & Clinical Psychology, 23*(1), 7-22.
- Allan, J., & Whybrow, A. (2007). Gestalt coaching. In S. Palmer, & A. Whybrow (Eds.), *Handbook of coaching psychology: A guide for practitioners* (pp. 133-159). London: Routledge.
- Allan, S. & Goss, K. (2012). Shame and pride in eating disorders. In J. Fox & K. Goss (Eds.), *Eating and its disorders* (pp. 154-166). UK: Wiley-Blackwell.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders, fourth edition, text revision, DSM-IV-TR*. Arlington, VA: American Psychiatric Association.
- Andersen, A. (1990). *Males with eating disorders*. Philadelphia, PA: Brunner/Mazel.
- Andersen, A., Cohn, L., & Holbrook, T. (2000). *Making weight: Men's conflicts with food, weight, shape, & appearance*. Carlsbad, CA: Gürze Books.
- Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller

- (Eds.), *The heart & soul of change: What works in therapy* (pp. 23-55).
Washington, DC: American Psychological Association.
- Barlett, C. P., Vowels, C. L., & Saucier, D. A. (2008). Meta-analyses of the effects of media images on men's body-image concerns. *Journal of Social & Clinical Psychology, 27*(3), 279-310.
- Bardone-Cone, A. M., Harney, M. B., Maldonado, C. R., Lawson, M. A., Robinson, D. P., Smith, R., & Tosh, A. (2010). Defining recovery from an eating disorder: Conceptualization, validation, and examination of psychosocial functioning and psychiatric comorbidity. *Behaviour Research and Therapy, 48*, 194-202.
- Bartlett, F. C. (1932). *Remembering: A study in experimental and social psychology*. Cambridge: Cambridge University Press.
- Bayes, A., & Madden, S. (2011). Early onset eating disorders in male adolescents: a series of 10 inpatients. *Australasian Psychiatry, 19*(6), 526-530.
- Beck, A. T., Rush, J. A., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: The Guilford Press.
- Beisser, A. (1970). Paradoxical theory of change. In J. Fagan & I. L. Shepherd (Eds.), *Gestalt therapy now: Theory, techniques, applications* (pp. 77-80). Palo Alto, CA: Science & Behavior Books.
- Berkman, N. D., Lohr, K. N., & Bulik, C. M. (2007). Outcomes of eating disorders: A systematic review of the literature. *International Journal of Eating Disorders, 40*(4), 293-309.
- Björk, T., & Ahlström, G. (2008). The patient's perception of having recovered from an eating disorder. *Health Care for Women International, 29*, 926-944.

- Björk, T., Wallin, K., & Pettersen, G. (2012). Male experiences of life after recovery from an eating disorder. *Eating Disorders: The Journal of Treatment & Prevention, 20*(5), 460-468. doi: 10.1080/10640266.2012.715529.
- Bogg, T., & Roberts, B. W. (2004). Conscientiousness and health-related behaviors: A meta-analysis of the leading behavioral contributors to mortality. *Psychological Bulletin, 130*(6), 887-919.
- Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa, and the person within*. New York: Basic Books, Inc.
- Buber, M. (1970). *I and Thou*. New York: Charles Scribner.
- Bulik, C. M., Berkman, N. D., & Brownley, K. A. (2007). Anorexia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders, 40*, 310-320.
- Bunnell, D. W. (2010). Men with eating disorders: The art and science of treatment engagement. In M. Maine, B. H. McGilley, & D. W. Bunnell (Eds.), *Treatment of eating disorders: Bridging the research-practice gap*, (pp. 301-316). Boston, MA: Academic Press/Elsevier, Inc.
- Cafri, G., Thompson, J. K., Ricciardelli, L., McCabe, M., Smolak, L., & Yesalis, C. (2005a). Pursuit of the muscular ideal: Physical and psychological consequences and putative risk factors. *Clinical Psychology Review, 25*, 215-239.
- Cafri, G., Yamamiya, Y., Brannick, M., & Thompson, J. K. (2005b). The influence of sociocultural factors on body image: a meta-analysis. *Clinical Psychology: Science and Practice, 12*(4), 421-433.

- Carlat, D., Camargo, C., & Herzog, D. (1997). Eating disorders in males: A report on 135 patients. *American Journal of Psychiatry*, *154*, 1127-1132.
- Carnell, S., Gibson, C., Benson, L., Ochner, C. N., & Geliebter, A. (2012). Neuroimaging and obesity: Current knowledge and future directions. *Obesity Reviews*, *13*, 43-56.
- Carper, T. L. M., Negy, C., & Tantleff-Dunn, S. (2010). Relations among media influence, body image, eating concerns and sexual orientation in men: A preliminary investigation. *Body Image*, *7*, 301-309.
- Carter, J. A. (2006). Theoretical pluralism and technical eclecticism. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet* (pp. 63-79). Washington, DC: American Psychological Association.
- Cash, T., & Pruzinsky, T. (2002). *Body image: A handbook of theory, research, and clinical practice*. New York: The Guilford Press.
- Clarkson, P. (2004). *Gestalt counselling in action* (3rd Ed.). London: Sage Publications.
- Cloak, N. L., & Powers, P. S. (2010). Science or art?: Integrating symptom management into psychodynamic treatment of eating disorders. In Maine, M., McGilley, B. H., & Bunnell, D. W. (Eds.) *Treatment of eating disorders: Bridging the research-practice gap* (pp. 143-161). London: Elsevier.
- Coleman, D. (2004). Theoretical evaluation self-test (TEST): A preliminary validation study. *Social Work Research*, *28*(2), 117-128.
- Cooper, M. (2012). Cognitive behavioural models in eating disorders. In J. Fox & K. Goss (Eds.), *Eating and its disorders* (pp. 204-224). UK: Wiley-Blackwell

- Costin, C. (2007). *The eating disorder sourcebook: A comprehensive guide to the causes, treatments, and prevention of eating disorders* (3rd ed.). New York: McGraw-Hill.
- Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd Ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Crisp, A. H. (1997). Anorexia nervosa as flight from growth: Assessment and treatment based on the model. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 248-277). New York: The Guilford Press.
- Crisp, A., & Burns, T. (1990). Primary anorexia nervosa in the male and female: A comparison of clinical features and prognosis. In A. Andersen (Ed.), *Males with eating disorders* (pp. 77-99). Philadelphia, PA: Brunner/Mazel.
- Cusumano, D. L., & Thompson, J. K. (1997). Body image and body shape ideals in magazines: Exposure, awareness, and internalization. *Sex Roles*, 37(9/10), 701-721.
- de Beer, Z., & Wren, B. (2012). Eating disorders in males. In J. Fox & K. Goss (Eds.), *Eating and its disorders* (pp. 427-441). UK: Wiley-Blackwell.
- Drummond, M. J. N. (2002). Men, body image, and eating disorders. *International Journal of Men's Health*, 1(1), 89
- Eating Disorders Awareness and Prevention, Inc. (EDAP) (1999). *The media, body image, and eating disorders*. Seattle, WA: EDAP.
- Erguner-Tekinalp, B., & Gillespie, C. W. (2010). Mental health practitioners' professional opinions of etiology of eating disorders: A cross-cultural study. *International Journal of Mental Health*, 39(3), 68-87.

- Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. New York: The Guilford Press.
- Feldman, M., & Meyer, I. (2007). Eating disorders in diverse lesbian, gay, and bisexual populations. *International Journal of Eating Disorders, 40*, 218-226.
- Feltman, K. A., & Ferraro, F. R. (2011). Preliminary data on risk factors and disordered eating in male college students. *Current Psychology, 30*, 194-202.
- Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. John Wiley & Sons, Ltd.
- Finzi-Dottan, R., & Zubery, E. (2009). The role of depression and anxiety in impulsive and obsessive-compulsive behaviors among anorexic and bulimic patients. *Eating Disorders, 17*, 162-182.
- Fodor, I. E. (1998). Awareness and meaning-making: The dance of experience. *Gestalt Review, 2*(1), 50-71.
- Fox, A. P., Larkin, M., & Leung N. (2011). The personal meaning of eating disorder symptoms: An interpretative phenomenological analysis. *Journal of Health Psychology, 16*(1), 116-125.
- Fox, J. R. E., & Power, M. J. (2009). Eating disorders and multi-level models of emotion: An integrated model. *Clinical Psychology and Psychotherapy, 17*, 240-267.
- Frankl, V. E. (2006). *Man's search for meaning*. (I. Lasch, Trans.). Boston, MA: Beacon Press. (Original work published 1946)
- Freeman, A. C. (2005). Eating disorders in males: A review. *South African Psychiatry Review, 8*, 58-64.

- Freid, C. M. (2007). *Beliefs associated with eating disorders and obsessive compulsive disorder: The development of the obsessive beliefs about body size and eating survey (OBBSES)*. Retrieved from ProQuest Digital Dissertations. (AAT 3301033)
- Freud, A. (1937). *The ego and the mechanisms of defense*. London: Hogarth Press and Institute of Psycho-Analysis.
- Garner, D.M., Vitousek, K. M., & Pike, K. M. (1997). Cognitive-behavioral therapy for anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 94-144).
- Gilbert, S. (2000). *Counselling for eating disorders*. London: Sage Publications.
- Glover, T., & Sharma, S. (2012). Physiological assessment of eating disorders. In J. Fox & K. Goss (Eds.), *Eating and its disorders* (pp. 42-60). UK: Wiley-Blackwell.
- Goodman, R. J. (2005). The mapping of eating disorders: a structural equation model of how peers, family & media influence body image & eating disorders. *Visual Communication Quarterly*, 12(3-4), 194-213.
- Goodsitt, A. (1997). Eating disorders: A self-psychological perspective. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of treatment for eating disorders* (pp. 205-228).
- Gordon, R. A. (2000). *Anorexia and bulimia: Anatomy of a social epidemic*. New York: Blackwell.
- Goss, K., & Allan, S. (2009). Shame, pride and eating disorders. *Clinical Psychology and Psychotherapy*, 16, 303-316.

- Goss, K., & Allan, S. (2012). An introduction to compassion-focused therapy for eating disorders (CFT-E). In J. Fox & K. Goss (Eds.), *Eating and its disorders* (pp. 303-314). UK: Wiley-Blackwell.
- Groesz, L. M., Levine, M. P., & Murnen, S. K. (2002). The effect of experimental presentation of thin media images on body satisfaction: A meta-analytic review. *International Journal of Eating Disorders, 31*, 1-16.
- Harrison, K. (2001). Ourselves, our bodies: thin-ideal media, self-discrepancies, and eating disorder symptomatology in adolescents. *Journal of Social and Clinical Psychology, 20*(3), 289-323.
- Harrison, K., & Hefner, V. (2006). Media exposure, current and future body ideals, and disordered eating among preadolescent girls: A longitudinal panel study. *Journal of Youth and Adolescence, 35*(2), 153-163.
- Haworth-Hoepfner, S. (2000). The critical shapes of body image: the role of culture and family in the production of eating disorders. *Journal of Marriage and the Family, 62*, 212-227.
- Hesse-Biber, S., Leavy, P., Quinn, C. E., & Zoino, J. (2006). The mass marketing of disordered eating and eating disorders: The social psychology of women, thinness and culture. *Women's Studies International Forum, 29*, 208-224.
- Hoek, H. W., & van Hoeken, D. (2003). Review of the prevalence and incidence of eating disorders. *International Journal of Eating Disorders, 34*(4), 383-396.
- Hubble, M. A., Duncan, B. L., & Miller S. D. (1999). Introduction. In Hubble, M. A., Duncan, B. L., & Miller S. D. (Eds.), *The heart & soul of change: What works in therapy* (pp. 1-19). Washington, D. C.: American Psychological Association.

- Hudson, J., Hirii, E., Pope, H., & Kessler, R. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replications. *Biological Psychiatry, 61*, 348-358.
- Husserl, E. (1970). *Logical investigation*. New York: Humanities Press.
- Jantz, G. L., & McMurray, A. (2010). *Hope, help & healing for eating disorders: A whole-person approach to treatment of anorexia, bulimia, and disordered eating*. Colorado Springs, CO: WaterBrook Press.
- Jokela, M. M., Hintsanen, M. M., Hakulinen, C. C., Batty, G. D., Nabi, H. H., Singh-Manoux, A. A., & Kivimäki, M. M. (2013). Association of personality with the development and persistence of obesity: a meta-analysis based on individual-participant data. *Obesity Reviews, 14*(4), 315-323.
- Joyce, P., & Sills, C. (2010). *Skills in Gestalt Counselling & Psychotherapy* (2nd ed.). London: Sage.
- Kappeler, F. (2004). A Gestalt approach to treating alcoholism and eating disorders. *Gestalt! 8*(2). Retrieved from <http://www.g-gej.org/8-2/alcoholism.html>.
- Kearnery-Cooke, A., & Steichen-Asch, P. (1990). Men, body image, and eating disorders. In Andersen, A. (Ed.) *Males with eating disorders* (pp. 54-74). New York: Brunner/Mazel, Inc.
- Keel, P. K., & Brown, T. A. (2010). Update on course and outcome in eating disorders. *International Journal of Eating Disorders, 43*(3), 195-204.
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London: SAGE Publications.
- Kirchner, M. (2000). Gestalt therapy theory: An overview. *Gestalt! 4*(3). Retrieved from

<http://www.g-gej.org/4-3/theoryoverview.html>.

- Kitson, C. (2012). Motivation to change. In J. Fox & K. Goss (Eds.), *Eating and its disorders*, (pp. 75-101). England: John Wiley & Sons, Ltd.
- Klump, K. L., Burt, S. A., Spanos, A., McGue, M., Iacono, W. G., & Wade, T. D. (2010). Age differences in genetic and environmental influences on weight and shape concerns. *International Journal of Eating Disorders*, *43*, 679-688.
- Koskina, N., & Giovazolias, T. (2010). The effect of attachment insecurity in the development of eating disturbances across gender: The role of body dissatisfaction. *The Journal of Psychology*, *144*(5), 449-471.
- Krasnow, M. (1996). *My life as a male anorexic*. New York: The Haworth Press.
- Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.). *Handbook of psychotherapy and behavior change* (pp. 143-189). New York, NY: Wiley.
- Lapides, F. (2010). Neuroscience: Contributions to the understanding and treatment of eating disorders. In Maine, M., McGilley, B. H., & Bunnell, D. W. (Eds.) *Treatment of eating disorders: Bridging the research-practice gap* (pp. 37-51). London: Elsevier.
- Levine, M. P., & Murnen, S. K. (2009). "Everybody knows that mass media are/are not [pick one] a cause of eating disorders": A critical review of evidence for a causal link between media, negative body image, and disordered eating in females. *Journal of Social and Clinical Psychology*, *28*(1), 9-42.
- Lindsley, O., Skinner, B. F., & Solomon, H. C. (1953). *Studies in behavior therapy* (Status Report I). Walthama, MA: Metropolitan State Hospital.

- Lundgren, J. D., Danoff-Burg, S., & Anderson, D. A. (2004). Cognitive-behavioral therapy for bulimia nervosa: An empirical analysis of clinical significance. *International Journal of Eating Disorders, 35*, 262-274.
- Mackewn, J. (1997). *Developing Gestalt counselling: A field theoretical and relational model of contemporary Gestalt counselling and psychotherapy*. London: Sage Publications.
- Magee, C. A., & Heaven, P. L. (2011). Big-Five personality factors, obesity and 2-year weight gain in Australian adults. *Journal of Research in Personality, 45*(3), 332-335.
- Mahler, M. (1968). *On human symbiosis and the vicissitudes of individuation*. New York: International Universities Press.
- Maine, M., & Bunnell, D. W. (2008). How do the principles of the feminist relational model apply to the treatment of men with eating disorders and related issues? *Eating Disorders: The Journal of Treatment & Prevention, 16*, 187-192.
- Maine, M., & Bunnell, D. W. (2010). A perfect biopsychosocial storm: Gender, culture, and eating disorders. In Maine, M., McGilley, B. H., & Bunnell, D. W. (Eds.) *Treatment of eating disorders: Bridging the research-practice gap* (pp. 3-16). London: Elsevier.
- Maine, M., McGilley, B. H., & Bunnell, D. W. (2010). Introduction: Eating disorders as biopsychosocial illnesses. In Maine, M., McGilley, B. H., & Bunnell, D. W. (Eds.) *Treatment of eating disorders: Bridging the research-practice gap* (pp. xxi-xxvi). London: Elsevier.

- Markus, H. (1977). Self-schemas and processing information about the self. *Journal of Personality and Social Psychology*, 35, 63–78.
- Markus, H., Hamill, R., & Sentis, K. P. (1987). Thinking fat: Self-schemas for body-weight and the processing of weight relevant information. *Journal of Applied Social Psychology*, 17, 50–71.
- Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Maslow, A. H. (1954). *Motivation and personality*. New York: Harper and Row.
- Mauer, R. (2005). Gestalt approaches with organizations and large systems. In A. L. Woldt & S. M. Toman (Eds.) *Gestalt therapy: History, theory and practice* (pp. 237-256). Thousand Oaks, CA: Sage Publications, Inc.
- McCrae, R. R., & John, O. P. (1992). An introduction to the five-factor model and its applications. *Journal of Personality*, 60, 175-215.
- McGilley, B. H., & Szablewski, J. K. (2010). Recipe for recovery: Necessary ingredients for the client's and clinician's success. In Maine, M., McGilley, B. H., & Bunnell, D. W. (Eds.) *Treatment of eating disorders: Bridging the research-practice gap* (pp. 3-16). London: Elsevier.
- Menstuff® (2012). *Eating disorders*. Retrieved from <http://www.menstuff.org/issues/byissue/eatingdisorders.html>
- Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco: Jossey-Bass.

- 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*(10), 69-71.
- Minuchin, S., Rosman, B., & Baker, I. (1978). *Psychosomatic families: Anorexia nervosa in context*. Cambridge, MA: Harvard University Press.
- Morey, L. C. (2007). *The Personality Assessment Inventory professional manual* (2nd ed.). Odessa, FL: Psychological Assessment Resources.
- Morgan, J. F. (2008). *The invisible man: A self help guide for men with eating disorders, compulsive exercise and bigorexia*. East Sussex, UK: Routledge.
- Moriarty, C. M. & Harrison, K. (2008). Television exposure and disordered eating among children: a longitudinal panel study. *Journal of Communication, 58*, 361-381.
- Morris, R. (2012). Assessment of occupation and social performance. In J. Fox & K. Goss (Eds.), *Eating and its disorders* (pp. 61-74). UK: Wiley-Blackwell.
- Morrison, T. G., Kalin, R., & Morrison, M. A. (2004). Body-image evaluation and body-image among adolescents: A test of sociocultural and social comparison theories. *Adolescence, 39*(155), 571-592.
- Moulding, N. T. (2007). "Love your body, move your body, feed your body": Discourses of self-care and social marketing in a body image health promotion program. *Critical Public Health, 17*(1), 57-69.
- Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

National Association of Anorexia Nervosa and Associated Disorders (ANAD). (n.d.).

Eating disorders statistics. Retrieved from <http://www.anad.org/get-information/about-eating-disorders/eating-disorders-statistics/>.

National Association for Males with Eating Disorders. (2011). *Statistics*. Retrieved from <http://namedinc.org/statistics.asp>

National Eating Disorders Association. (2010). *Fact sheet on eating disorders*. Retrieved from <http://www.nationaleatingdisorders.org/in-the-news/press-room.php>

National Eating Disorders Association (n.d.). *Males and eating disorders*. Retrieved from <http://www.nationaleatingdisorders.org/males-and-eating-disorders>

National Institute for Health and Care Excellence (NICE). (2004). Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. *National Clinical Practice Guideline Number CG9*. London: National Institute for Health and Care Excellence. Retrieved from: <http://guidance.nice.org.uk/CG9/Guidance/pdf/English>

Noordenbos, G. (2011). When have eating disordered patients recovered and what do the DSM-IV criteria tell about recovery? *Eating Disorders, 19*, 234-245.

Nordbø, R. H. S., Espeset, E. M. S., Gulliksen, K. S., Skarderud, F., & Holte, A. (2006). The meaning of self-starvation: Qualitative study of patients' perception of anorexia nervosa. *International Journal of Eating Disorders, 39*, 556-564.

Norris, M. L., Apsimon, M., Harrison, M., Obeid, N., Buchholz, A., Henderson, K. A., & Spettigue, W. (2012). An examination of medical and psychological morbidity in adolescent males with eating disorders. *Eating Disorders: The Journal of*

- Treatment & Prevention*, 20(5), 405-415. Retrieved from <http://dx.doi.org/10.1080/10640266.2012.715520>.
- O'Dea, J. A., & Abraham, S. (1999). Association between self-concept and body weight, gender, and pubertal development among male and female adolescents. *Adolescence*, 34(133), 70-79.
- Onorato, R. S., & Turner, J. C. (2004). Fluidity in the self-concept: The shift from personal to social identity. *European Journal of Social Psychology*, 34, 257-278.
- Pavlov, I. P. (1927). *Conditioned reflexes*. London: Oxford University Press.
- Peñas-Lledó, E., Fernández, J. D. & Waller, G. (2004). Association of anger with bulimic and other impulsive behaviours among non-clinical women and men. *European Eating Disorders Review*, 12, 392-397.
- Perls, F. S. (1969). *Ego, hunger, and aggression: The beginning of Gestalt therapy*. NY: Random House.
- Perls, F. S., Hefferline, R., & Goodman, P. (1951). *Gestalt therapy: Excitement and growth in the human personality*. NY: Julian Press.
- Peterson, K. A., Paulson, S. E., & Williams, K. K. (2007). Relations of eating disorder symptomology with perceptions of pressures from mother, peers, and media in adolescent girls and boys. *Sex Roles*, 57, 629-639.
- Pettersen, G., & Rosenvinge, J. H. (2002). Recovery from eating disorders – a patient perspective. *Eating Disorders*, 10, 61-71.
- Pettersen, G., Rosenvinge, J. H., & Wynn, R. (2011). Eating disorders and psychoeducation – patients' experiences of healing processes. *Scandinavian Journal of Caring Sciences*, 25, 12-18.

- Piaget, J. (1929). *The child's conception of the world*. London: Routledge and Kegan Paul.
- Piaget, J. (1932/1965). *The moral judgment of the child*. London: Free Press.
- Piaget, J. (1987a). *Possibility and necessity* (Vol. 1). Minneapolis: University of Minnesota Press.
- Piaget, J. (1987b). *Possibility and necessity* (Vol. 2). Minneapolis: University of Minnesota Press.
- Polivy, J., & Herman, C. P. (2002). Causes of eating disorders. *Annual Review of Psychology*, 53, 187-213.
- Pope, H., Phillips, K., & Olivardia, R. (2000). *The Adonis complex: The secret crisis of male body obsession*. New York: NY: Free Press.
- Rabinor, J. R. (2002). *A starving madness: Tales of hunger, hope & healing in psychotherapy*. Carlsbad, CA: Gürze Books.
- Random House. (n.d.). *The secret language of eating disorders: Peggy Claude-Pierre and the Montreux Counselling Centre*. Retrieved from <http://www.randomhouse.com/features/eatingdisorders/about.html>
- Ravi, S., Forsberg, S., Fitzpatrick, K., & Lock, J. (2009). Is there a relationship between parental self-reported psychopathology and symptom severity in adolescents with anorexia nervosa? *Eating Disorders*, 17, 63-71.
- Reed, G. M., & Eisman, E. J. (2006). Uses and misuses of evidence: Managed care, treatment guidelines, and outcomes measurement in professional practice. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based*

- psychotherapy: Where practice and research meet* (pp. 13-35). Washington, DC: American Psychological Association.
- Reich, W. (1972). *Character analysis* (3rd ed.). New York: Simon and Schuster.
(Original work published 1945)
- Ricciardelli, L. A., & McCabe, M. P. (2004). A biopsychosocial model of disordered eating and the pursuit of muscularity in adolescent boys. *Psychological Bulletin*, *130*(2), 179-205.
- Richards, P. S., Baldwin, B. M., Frost, H. A., Clarksly, J. B., Berrett, M. E., & Hardman, R. K. (2000). What works for treating eating disorders? Conclusions of 28 outcome reviews. *Eating Disorders*, *8*, 189-206.
- Rogers, C. (1951). *Client-centered therapy: Its current practice, implications and theory*. London: Constable.
- Rohlinger, D. A. (2002). Eroticizing men: Cultural influences on advertising and male objectification. *Sex Roles*, *46*(3/4), 61-74.
- Rørtveit, K., Åström, S., & Severinsson, E. (2009). The feeling of being trapped in and ashamed of one's own body: A qualitative study of women who suffer from eating difficulties. *International Journal of Mental Health Nursing*, *18*, 91-99.
- Ryan, R. M., & Deci, E. L. (2012). Multiple identities within a single self: A self-determination theory perspective on internalization within contexts and cultures. In M. R. Leary, & J. P. Tangney (Eds.) *Handbook of Self and Identity* (2nd ed.), pp. 225-246. New York: The Guilford Press.
- Saxen, R. (2007). *The good eater: The true story of one man's struggle with binge eating disorder*. Oakland, CA: New Harbinger Publications, Inc.

- Schacter, D. L. (1999). The seven sins of memory: Insights from psychology and cognitive neuroscience. *American Psychologist*, 54(3), 182-203.
- Schaffer, N. A. (2003). Binge-eating and other eating disorders. In Leahy, R. L. (Ed.) *Roadblocks in cognitive-behavioral therapy* (pp. 195-214). New York: Guilford Press.
- Seidinger, F. M., Garcia, C., Böttcher-Luiz, F., & Turato, E. R. (2011). Dropout in the treatment for anorexia nervosa and bulimia: A systematic review from the international databases. *European Psychiatry*, 26, p. 738.
- Shandler, S. (1999). *Ophelia speaks: Adolescent girls write about their search for self*. New York: Harper Perennial.
- Shure, J. (2012). *The role of shame in eating disorders*. Retrieved from <http://www.kripalu.org/article/177>
- Silverman, J. A. (1990). Anorexia nervosa in the male: Early historic cases. In A. E. Andersen (Ed.), *Males with eating disorders* (pp. 3-8). New York: Bruner/Mazel, Inc.
- Simon, S.N. (2009). Applying Gestalt theory to coaching. *Gestalt Review*, 13(3), 230-240.
- Smolak, L., & Levine, M. P. (1994). Critical issues in the developmental psychopathology of eating disorders. In L. Alexander, & B. Lumsden (Eds.), *Understanding eating disorders* (pp. 37-60). Washington, DC: Taylor & Francis.
- Smolak, L., Murnen, S. K., & Thompson, J. K. (2005). Sociocultural influences and muscle building in adolescent boys. *Psychology of Men and Masculinity*, 6, 227-239.

- Soban, C. (2006). What about the boys?: Addressing issues of masculinity within male anorexia nervosa in a feminist therapeutic environment. *International Journal of Men's Health*, 5(3), 251-267.
- Spoth, J., Toman, S., Leichtman, R., & Allan, J. (2013). Gestalt Approach. In J. Passmore, D. B. Peterson, & T. Freire (Eds.), *The Wiley-Blackwell handbook of the psychology of coaching and mentoring* (pp. 385-406). UK: John Wiley & Sons, Ltd.
- Stein, K. F. (1996). The self-schema model: A theoretical approach to the self-concept in eating disorders. *Archives of Psychiatric Nursing*, X(2), p. 96-109.
- Steinhausen, H. (2002). Outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry*, 159, 1284-1293.
- Stevenson, H. (2005). Gestalt Coaching. *OD Practitioner*, 37(4), 35-40.
- Stevenson, H. (2010). Parastubsdox: A Gestalt theory of change for organizations. *Gestalt Review*, 14(2), 111-126.
- Stice, E. (2001). A prospective test of the dual-pathway model of bulimic pathology: mediating effects of dieting and negative affect. *Journal of Abnormal Psychology*, 110, p. 1-12.
- Stormer, S. M., & Thompson, J. K. (1996). Explanations of body image disturbance: A test of maturational status, negative verbal commentary, social comparison, and sociocultural hypotheses. *International Journal of Eating Disorders*, 19(2), 193-202.

- Støving, R. K., Andries, A., Brixen, K., Bilenberg, N., & Hørder, K. (2011). Gender differences in outcome of eating disorders: A retrospective cohort study. *Psychiatry Research, 186*, 362-366.
- Striegel-Moore, R., Rosselli, F., Perrin, N., DeBar, L., Wilson, G., May, A., & Kraemer, H. C. (2009). Gender difference in the prevalence of eating disorder symptoms. *International Journal of Eating Disorders, 42*, 471-474.
- Strober, M. (1997). Consultation and therapeutic engagement in severe anorexia nervosa. In D. M. Garner & P. E. Garfinkel (Eds.), *Handbook of Treatment for Eating Disorders*. (pp. 229-247). New York: The Guilford Press.
- Strober, M., Freeman, R., & Morell, W. (1997). The long-term course of severe anorexia nervosa in adolescents: Survival analysis of recovery, relapse, and outcome predictors over 10-15 years in a prospective study. *International Journal of Eating Disorders, 22*, 339-360.
- Stromberg, G., & Merrill, J. (2006). *Feeding the fame: Celebrities tell their real-life stories of eating disorders and recovery*. Center City: MN: Hazelden.
- Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating disorders in men: Underdiagnosed, undertreated, and misunderstood. *Eating Disorders: The Journal of Treatment & Prevention, 20*(5), 346-355.
<http://dx.doi.org/10.1080/10640266.2012.715512>.
- Stubbs, R. J., & Lavin, J. H. (2013). The challenges of implementing behavior changes that lead to sustained weight management. *Nutrition Bulletin, 38*(1), 5-22.
- Sullivan, P. (1995). Mortality in anorexia nervosa. *American Journal of Psychiatry, 152*(7), 1073-1074.

- Tantleff-Dunn, S., Barnes, R., & Larose, J. G. (2011). It's not just a "woman thing": The current state of normative discontent. *Eating Disorders, 19*(5), 392-402.
- Tiggemann, M., & Slater, A. (2004). Thin ideals in music television: A source of social comparison and body dissatisfaction. *International Journal of Eating Disorders, 35*, 48-58.
- Tønnesvang, J., Sommer, U., Hammink, J., & Sonne, M. (2010). Gestalt therapy and cognitive therapy – Contrasts or complementarities? *Psychotherapy Theory, Research, Practice, Training, 47*(4), 586-602.
- Tylka, T. L. (2006). Development and psychometric evaluation of a measure of intuitive eating. *Journal of Counseling Psychology, 53*(2), 226-240.
- Valois, R. F., Zullig, K. J., Huebner, E. S., & Drane, J. W. (2003). Dieting behaviors, weight perceptions, and life satisfaction among public high school adolescents. *Eating Disorders, 11*, 271-288.
- van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. New York: State University of New York Press.
- Vanderlinden, J. (2008). Many roads lead to Rome: Why does cognitive behavioural therapy remain unsuccessful for many eating disorder patients? *European Eating Disorders Review, 16*, 329-333.
- Waller, G., & Barter, G. (2005). The impact of subliminal abandonment and unification cues on eating behavior. *International Journal of Eating Disorders, 37*, 156-160.
- Walsh, B. T. (2011). The importance of eating behavior in eating disorders. *Physiology & Behavior, 104*, 525-529.

- Weltzin, T., Cornella-Carlson, T., Fitzpatrick, M. E., Kennington, B., Bean, P., & Jefferies, C. (2012). Treatment issues and outcomes for males with eating disorders. *Eating Disorders: The Journal of Treatment & Prevention, 20*(5), 444-459. <http://dx.doi.org/10.1080/10640266.2012.715527>.
- Wertz, F. J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167-177.
- Whetstone, L.M., Morrissey, S.L., & Cummings, D.M. (2007). Children at risk: The association between perceived weight status and suicidal thoughts and attempts in middle school youth. *Journal of School Health, 77*(2), 59-66.
- Whitney, J., Murray, J., Gavan, K., Todd, G., Whitaker, W., & Treasure, J. (2005). Experience of caring for someone with anorexia nervosa: Qualitative Study. *The British Journal of Psychiatry, 187*, 444-449.
- Williamson, D. A., Martin, C. K., & Stewart, T. (2004). Psychological aspects of eating disorders. *Best Practice & Research Clinical Gastroenterology, 18*(6), 1073-1088.
- Wilps, R. F. (1990). Male bulimia nervosa: An autobiographical case study. In A. Andersen (Ed.), *Males with eating disorders* (pp. 9-29). Philadelphia, PA: Brunner/Mazel.
- Woodside, D. B., Garfinkel, P. E., Lin, E., Goering, P., Kaplan, A. S., Goldbloom, D. S. & Kennedy, S. H. (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*(4), 570-574.

- Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. New York: HarperCollins.
- Yontef, G. (2005). Gestalt therapy theory of change. In A. L. Woldt & S. M. Toman (Eds.), *Gestalt therapy: History, theory, and practice* (pp. 81-100). Thousand Oaks, CA: Sage Publications.
- Yontef, G. (2007). The power of the immediate moment in Gestalt therapy. *Journal of Contemporary Psychotherapy*, 37, 17-23.
- Zadoff, A. (2007). *Hungry*. Philadelphia, PA: Da Capo Press.
- Zinker, J. (1977). *Creative Process in Gestalt Therapy*. New York: Brunner/Mazel Publishers.

APPENDICES

APPENDIX A
INFORMED CONSENT FORM



Informed Consent for Participation in the study:
Men making meaning of eating disorders: A qualitative study.
Investigator: Robin Leichtman, PhD. Student, Cleveland State University

Dear Participant,

I am a doctoral student at Cleveland State University conducting my dissertation research. This study is under the supervision of Dr. Sarah Toman. The purpose of this study is to describe how men experience living with an eating disorder. Specifically, I am asking you to participate in an interview with me that may last up to two hours. This interview is voluntary and requires your permission to be audio recorded.

Your participation may involve the possible risk of some distress when talking about your eating disorder symptoms and reliving past experiences. For this reason, it is highly recommended that you consider meeting with your mental health practitioner following this meeting if you need to work through any thoughts or feelings experienced due to our interview. A referral list of mental health providers with expertise in eating disorder treatment is provided should you need assistance in locating a mental health practitioner. Additionally, there is a possible risk in that confidentiality may be breached by virtue of the recruitment process. Through the recruitment process, other individuals may be aware of your participation in the study; however, the investigator will not share any data collected with recruitment sites including disclosing whether or not a recruit chose to participate. Further, no potentially identifying information will be used in the presentation of the results. In the final report, a false name will represent your information, age and gender.

Following the interview, you may feel there is more information you would like to share, so we could schedule a follow-up interview at your request. Additionally, within two weeks of the interview, you will be given a copy of our transcribed interview to check for accuracy, as well as given another opportunity to add any additional thoughts or insights. There are no direct benefits for you as a volunteer participant, except giving voice to your experiences might be experienced as therapeutic. You may also benefit from knowing that you are contributing to professional knowledge about men's experiences with eating disorders.

Mailing Address: 2120 Euclid Avenue, JH275 • Cleveland, Ohio 44115-2264
Campus Location: John Hall, Room 275 • 3615 Euclid Avenue • Cleveland, Ohio
(216) 687-4663 • Fax (216) 687-5278

You may elect to receive a summary of the results when the research is completed. Interview transcripts and taped sessions will be kept in a locked file to which only the student investigator has access. Of course, if you decide to participate, you may withdraw your participation at any time without penalty. If you have additional questions that you want answered at any time during the study, you may email me at leichtmanr@gmail.com or my supervisor, Dr. Sarah Toman at stoman@therapyonliberty.com.

This study has been reviewed and approved by the Cleveland State University Institutional Review Board (IRB) whose task it is to make sure that research participants are protected from harm. If you wish to have additional information about your rights as a research participant, contact the Cleveland State University IRB at (216) 687-3630.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I am at least 18 years of age. I consent voluntarily to participate as a participant in this research. I also consent to be audio recorded.

Print Name of Participant _____ Date _____

Signature of Participant _____

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual is at least 18 years of age, has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this Informed Consent Form has been provided to the participant.

Robin Leichtman
Student Researcher

Date _____

APPENDIX B

RESEARCH INFORMATION SHEET

Research Needed On Men & Eating Disorders CSU Doctoral Student Recruiting Now!

I am a doctoral student at Cleveland State University investigating men's experiences with having an eating disorder.

This phenomenological study hopes to discover:

- What factors encouraged you to seek treatment?
- What challenges did you have to overcome during the recovery process?
- What fostered recovery?

I am recruiting adult males (18 years of age or older) currently in recovery/maintenance from a clinically diagnosed eating disorder.

Interviews will be held at a site that will be convenient and agreeable for each participant including Skype or other Voice Over IP service. Interviews may last anywhere from 1-2 hours and will be audio recorded.

Participants are assured confidentiality to the extent that no potentially identifying characteristics, such as place of employment, will be disclosed. In the final report, a false name will represent your information.

TO PARTICIPATE,

PLEASE E-MAIL
Robin Leichtman at:

LeichtmanR@gmail.com

This study has been reviewed and approved by the Cleveland State University Institutional Review Board whose task it is to make sure that research participants are protected from harm. If you wish to have additional information about your rights as a research participant, contact the CSU IRB at 216-687-3630.

If you decide to participate, you may withdraw your participation at any time without penalty.

There are no direct benefits to the participants associated with this dissertation research; however, giving voice to one's experience is often regarded as being helpful.

Interview transcripts and taped sessions will be kept in a locked file to which only I will have access.

You may elect to receive a summary of the results when the research is completed.

APPENDIX C

PARTICIPANT CHARACTERISTICS AND DEMOGRAPHICS SURVEY

Dissertation:
How Men Make Meaning of Eating Disorders

Student Investigator: Robin Leichtman, M.Ed., PC, Doctoral Student

Note: This demographic form is intended to gather some information about you. Please respond to as many of the items below that you are able. All information will remain confidential, and you will receive a pseudonym so that your identity is not revealed in this study. Some of your responses might be explored in the initial interview. If you have any questions about this form, please contact me at leichtmanr@gmail.com.

Name _____ Date Completed: _____

Contact Information for follow-up and delivery of transcript (check preference):

Phone _____ email _____

Pseudonym you prefer to be used in the study: _____

Date of Birth _____

Date of Diagnosis _____ By Whom? _____

Eating Disorder Diagnosis _____ Other Diagnosis _____

For how long have you had an eating disorder? _____

How do you self-identify with respect to your:

Racial and ethnic identity _____

Religious background _____

Sexual Orientation _____

Briefly describe your hopes for participating in this

study: _____

APPENDIX D

INTERVIEW TRANSCRIPTS AND RESEARCHER'S JOURNAL EXCERPTS

Introduction

Portions of the transcripts are offered here to provide further insight into how the researcher denoted themes. I share participants' responses to each interview question in the order that they were recorded. In other words, the first interview was with Scott; the second with Jay; third with Casey; fourth, Michael; fifth, Chris; and sixth, Edward. My journal entries are sporadically shared to demonstrate how I bracketed personal bias.

Participants' Interview Responses

Question 1: What has been your eating disorder experience starting with how it began?

Scott:

I don't think I really did ever binge. I think it was the type of food. It was the fast food and yeah, sometimes the quantity and things . . . I would have to be out of the house by 5:00 in the morning, I had to be at work by 7:00. Go through Hardee's McDonald's get a couple breakfast sandwiches. I pack like a small lunch and eat that for lunch and on the way home. I work 16-hour shifts. On my way home, 11:30-midnight, going through McDonald's getting a couple of sandwiches. It is the quality. I don't really think it is ever been the quantity. It's always been the quality of food and I think that is what's been my downside, you know. And I have been big ever since I can remember. I lost my dad at a very young age. I was 7 . . . He worked in a prison, he was a guard in a prison and he was stabbed 15 or 16 times by an inmate.

Researcher's Journal Excerpt

When I lived in Los Angeles, my first time really being away from home, I depended on fast food restaurants for most of my meals .

Jay

I first developed eating disorder probably in terms of, um, behaviors when I was around 16 years old. I probably had been having eating disorder thoughts 2-3 years prior to that. Eating disorder started first with significant... running... my thoughts over age 16

to 17 were increasingly about food, body, size and shape... by around age 17, I had started significantly reducing both food intake and food type... while I continued to run... I began weighing myself constantly... when I finished high school, I went to college, I continued to restrict on a relatively on-going basis and to exercise on a relatively on-going basis but less so... the weight loss continued Freshman and half-way into Sophomore year of college... I had what was diagnosed then as a panic attack... No diagnosis was made of eating disorder. All of these things we are talking about occurred prior to... a formal DSM III diagnosis of eating disorders...

Researcher's Journal Excerpt

I wonder how many times he has told this story; it seems so polished.

Casey

I would say if I think back far enough even in high school... I was typically at home on my own in the afternoon after school and so I would have tendency to watch TV and just kind of sit there and graze on junk food... It probably brought about just some unhealthy eating habits even at that early age... I didn't translate that into any kind of eating disorder. That was how a teenager ate. I was pretty active, I played sports in high school and did a lot so I never gained weight. I was a normal weight teenage kid. Probably through college... I went away to school... I think my biggest challenge came after I got out of school when all of a sudden I had more money and I was working and I had money to buy what I wanted to eat. And living on my own being a bachelor... I just overate and it became slowly a bad pattern of nutrition and portion sizes. I think a lot of that is what it came down to and I just started to eat larger volumes of food at one sitting... It didn't faze me at all. Then... I became more engrossed in my career and more sedentary and then really within the first year of being out of college I put on like 40 or 50 pounds of excess weight that I didn't have before, and wasn't really noticing it until I saw a picture of myself and went 'wow.' I think I went to a routine doctor's appointment and he said you really have to watch your weight. I can still remember he said, 'there's two of you living inside of you.'

Chris

I guess 2002, [age 13/14] probably, started having trouble... it didn't... progress as bad habits... I went into treatment in 2004 and then I would say, I've been recovered over

those years since then. Probably when I was like 18 or 19, probably 19, is when I was in full recovery... in the sense of no longer... having any impulses or thoughts or anything like that... first of all, we kind of break down eating disorders into two categories, anorexia and well actually three, binge eating as well. Um, and you know, it's kind of restrictive, I think for almost everyone... it manifests in different ways, different thoughts from it... speaking more from my experience, I think it was more something to control in a way you can escape from other troubles or things you don't want to have to think about or deal with. If you just, in a sense, obsess with one thing and you kind of escape into that... I would say... for me, that's how it makes sense. I don't think I was ever like I thought about image and stuff, because for me, I was overweight as a kid. So to me, at first, I think it felt, I started to get more compliments and stuff. So, I think it just kind of happened... if I'm getting to a more healthy weight at the time, then this is something I can get some self-esteem... and then at some point, you know, it became kind of out of control. I don't think I ever looked in a mirror and had some false idea of what I looked like. Like when it was bad, I would look in the mirror and say, "wow, I'm really skinny." Like "I don't look good, I look sick." But there wasn't really anything I could do about it. You know, I feel like I did have denial but um, you know, I kind of wanted it to end, but I didn't know how to. And I think that at that point you are so mentally exhausted that you can't really help yourself anymore at that point.

Researcher's Journal Excerpt

His story is really unique having had two completely different kinds of interactions with kids his own age. I wonder how it is that his brain did not register a distorted image. He saw how skinny he was and still wasn't able to stop. His story gives a lot of credence to biological factors.

Edward

Prior to my diagnosis at age 16... my eating disorder actually started at around age 10. And at that point, you know my parents definitely knew something was going on and so did my family care doctor, but no one really noticed it was an eating disorder. Specifically, when it started out at age 10, it was definitely... like restriction leading to like anorexia. And so, I would say my very first experience with it was that no one knew what was really happening... I can remember at age 16... when I was my worst weight-wise, still the family-care doctor I had since age 10, still never mentioned anything about an eating disorder, almost as though he didn't know what they were. And so, I even went to the emergency room one time because I had passed out, and my heart rate was below 30 and my weight was terrible and even the emergency room doctor didn't know or didn't say anything about an eating disorder. And so, it wasn't until pretty much my parents brought me to more of the psychological side of health care that it was really recognized. And so I would say that was definitely, you know, looking back, it makes me feel a little bit frustrated regarding... you know, I ask myself: is it because I am a guy that they weren't considering an eating disorder... or is it just because they didn't know? Overall, I just felt that the education these physicians had was not comprehensive to cover that.

Researcher's Journal Excerpt

I wonder if some of Edward's thoughts were ideas he assimilated as of a result of treatment. He brought up the idea of being a guy and nobody was diagnosing me with an eating disorder... isn't that my point... but it didn't sound like his words.

Question 2: How do you make sense of having an eating disorder?**Scott**

I think it is society, it's being complacent. It's what I knew. I didn't know any different until I came to [the nursing home]. That's what I knew . . . I truly believe when I was in first grade, when all that happened the year when my dad got killed, uh, that I don't know . . . we never had any counseling, nothing . . . I do think with all that trauma that has a lot to do with what's happened with my weight. I really think that had a lot to do with a lot of it . . . I guess food was a comfort. I really do. I mean if that had never happened, [dad being murdered] I don't think my dad would have allowed it.

Researcher's Journal Excerpt

I can relate to emotional eating... I wonder why others allowed him to get so big? He said "I think society." At first, I thought the fast-pace, need for immediate gratification and convenience. But maybe he meant that nobody said or did anything.

Jay

I think purely biological... I was just wired that way. You know, I had all the things people with eating disorders had. I was highly ordered, I was perfectionistic, I was hyper sensitive... I believe the biological studies. I believe the insulin studies. I believe those things deeply. I think it just segued at some point into rigidity, and into malnutrition, and into endorphin release, dopamine and all that kind of stuff that happens when you are disordered... there was certainly nothing that... was promoted in my environment. I think I am, I am living proof that eating disorders are not created by families, or society, or diets, or whatever. That was just totally nonexistent.

Researcher's Journal Excerpt

I have to respect that this is his reality. If his meaning-making is that this is purely biological, I have to report it this way.

Casey

I think that is part of my problem, is that I really didn't make sense of it. It was just something I took for granted as time went on... I have gained and lost 100 lbs. four times in my life. And from that time in 1982 until the present... the first two times was the same type of thing – okay, time to buckle down, time to exercise more and then by the third time the exercise wasn't enough. Now, I really have to start watching what I'm eating. The third time was just before I was married, you know, so I was trying to impress my fiancé at the time and so I just knuckled down and ate well, and you know, it helped that she was cooking well and exercised diligently and bicycled and so forth. My eating habits deteriorated again after I got married and then, I stopped caring about it a lot more; it didn't really bother me. I was not eating properly. It was kind of a degradation of caring about it, not like your suicidal in your eating habits but you know, I'm fine with this, just leave me alone... It's not a priority. Just leave me alone. I work hard, I make a good living, so my bad thing in life is I don't eat well and I weigh too much.

Researcher's Journal Excerpt

I get this. I'm quite happy in my little world, but when I walk outside and I feel "measured" then my bad thing in life is I let myself go and I weigh too much and I'm undesirable. "Just leave me alone" – yeah! What difference does it make, really?! Why can't we just accept each other for what is on the inside?

Michael

I think emotional support... I think I turned to [food] for basically emotional support... it became an addiction... It kind of snowballed ... took on a life of its own. But I think I would say it probably started out as emotional support ... my mom was very loving and caring and kind and stuff like that but, ... the house ... there was a lot of yelling and stuff and just kind of, um, difficult. It was kind of difficult at times, so ... I turned to food. Food was comforting. It was nurturing. It was reliable. If you had the money, it was reliable ... It was a reliable comfort for when your feelings get triggered. You know, when you are not feeling comfortable with yourself or um, comfortable in situations and stuff, you know. It was a reliable friend. You know I didn't have too many friends. I had some friends, but I didn't have too many. I pretty much played by myself and did my own thing... it was kind of like almost like a friend... Like a buddy, a companion.

Chris

I don't think anyone really understands why, you know, it happened or all the steps. I'm pretty sure for most people it is a pretty complex thing. I can't really point towards one thing or one reason and in a way, when you go into treatment, you're told reasons why some people. I'm trying to not have that influence me directly that I think that is exactly what it is, but if I could paint a picture of what is probably the closest thing, that's probably it. Because when you are in the midst of it, you don't understand why.

Researcher's Journal Excerpt

I'm trying not to have the research influence me!

Edward

I've always seen it more as a ... disease. That isn't the best word for it, but definitely something that wasn't something I wanted, just like a person doesn't want to have cancer or something like that. And so, I think I've seen it more as a disease probably to hide behind the social stigma of it because if it is a disease, I think I say to myself that it should be more acceptable in society, but at the same time knowing that it is, you

know, a mental health condition as well ... around that age 16 or so ... when I was officially diagnosed and I had to take time off from high school ... if I were honest to people my age in school about where I was and all that stuff; for instance, my best friend, ... he would make really bad jokes about it all the time and eventually he just never talk to me again. And so I think it supported the notion you just can't talk about it.

Researcher's Journal Excerpt

Since I've been researching eating disorders, I became convinced that the media influence was really powerful. I think a lot of this started in my undergraduate years when the Israel-Palestinian conflict was on the news 24/7 and people had the impression that Israel was a country as large as the United States in size when it is smaller than the state of New Jersey. I think that is how I see the power of the media. When a message keeps getting repeated over and over, the public seems to take it to a whole new level. The Hollywood "ideal" image ... "beautiful" thin people selling beer and chips. How can they stay that thin and drink beer? ...except Michael, none of these participants seem too influenced by the media. I was completely expecting comments like I wanted to look like

Brad Pitt or someone...

Question 3: What was your specific diagnosis? How did that change over time?

Scott

I wouldn't classify it as [binge-eating disorder] because I was not eating 10-15,000 calories a day ... I don't think I ever ate that much. But, I didn't classify it -- What's funny I never looked at myself being as big as I was. In the bathroom it was hard to look at myself in the mirror because when I looked at myself in the mirror you're that big ... I actually had to stop working about April or May of 2008 and I went really downhill from there ... When I walked into the emergency room back home my oxygen level was in the 30s and 40s and I was still upright. I was surprised at that.

Jay

[I] was put on valium at that time for my panic and anxiety ... No diagnosis was made of eating disorder ... what I was able to do was establish a set of connections with others through working on this play together and during that time, I ... met my wife-to-be ... She began the process of re-feeding me ... [at the time of the interview] I am pretty healthy. I feel very healthy. I feel massively recovered, which is not to say I cannot

recover more. Just so you know, that's how I hold this. I hold this as massively recovered, but it doesn't mean I can't recover more. I'm part of a group of 70 professionals who have a history of disorders; we communicate and meet every year ... I feel very, very gratified to be in recovery and ... it's amazingly gratifying to tell the story.

Casey

I see myself in a lot more positive [way]. I knew once I had the surgery that the weight was going to come off, um, just simply because I wasn't going to be able to use much because you know, and behaviorally, you know, that helped me adjust my brain and to say, okay, you now got this tool so now you can follow the regimen of the right eating habits ... I was very rigid about following the eating guidelines ... and that discipline helped...the weight started coming off like 5-7 lbs. a week and all I was really doing was walking ... its just positive reinforcement ... Your losing weight, you want to lose more...It's just having the ability to eat less and the positive reinforcement and one of the best things, in all honesty, ... everybody is very congratulatory, supportive of it and that just helps to feed the whole process.

Michael

I don't think it really changed over time ... I never really got into bulimia or anorexia ... It turned into a real struggle with my weight. You know, I was very heavy, um, I gained a lot of weight. I was constantly going on diets, though. So, I would go on a really strict diet for like a week and a half and then I would go off it and I would be bingeing for a couple of months. Then I would go back to a really strict diet for like a week and a half. You know, I was exercising, too. I was into fitness and stuff, which is kind of bizarre. Um, so I was exercising and lifting weights and stuff. I was delivering papers; I was riding a bike for 3 hours a day and yet, I was still significantly overweight. You know, so my diet consisted of McDonald's, Burger King, pizza, cookies, sugar-coated cereal, um, you know, things like that, ... I think it was going on before then but it kind of hit another level when I got access to money, then it hit another level.

Chris

Anorexia.

Edward

First anorexia, and then, um, I guess once I was in residential at age 19, they said it was more EDNOS... because I was restricting, I was purging, but officially, according to my BMI wasn't anorexic.

Question 4: What do you believe impacted you most in your development of an eating disorder? Media? Peer relations? Family? Personality trait (e.g., low self-esteem, body dissatisfaction)?

Scott

I think being complacent. I'll start it tomorrow, I'll do it tomorrow. And tomorrow never came until I came [here] ... I have never been bed-bound, never been in a wheelchair I've always been ambulatory ... [In 2007] for about 4 or 5 months my mom and I did like Nutrisystem and I lost about 60-70 pounds and I got to where I was on medical leave and was able to go back to work about 4 or 5 months later. And then, I would say beginning of '08 ... the weight just started piling back on ... I probably gained more than what I actually lost ... I was such a shy individual and I would just take it, you know, people talking behind my back.

Researcher's Journal Excerpt

I didn't experience Scott as shy. As he loses weight, is he coming out of his shell?

Jay

None of those things. I was aware that being fat was an insult. You know, I was aware of that ... I was aware that there were images of men hyper thin particularly in the rock and roll world, which was a world that inspired ... that I could achieve, so certainly there was a reinforcing aspect but I don't think it was causative in any way, shape or form. If you asked me what I really wanted to look like, it wasn't like that. In fact, I could move that way but I would have preferred to be muscular and strong and prefer to be a wide receiver for the Browns.

Casey

I'd say the first time ... I was a young guy and single and you knew if you were going to be a fat kid you weren't going to find a good looking woman and so, I was more driven from that standpoint of, you know, you're not going to be much of a find if you're overweight ... The second time, ... was probably kind of more of the same. You've

allowed it to deteriorate and so let's do this and make a commitment out of it. The third time was definitely because I was now in a relationship and ... my former wife, was very supportive of it and so I did it as part of our relationship ... it was almost kind of retaliatory that I didn't care anymore. This relationship is done so I'm not worried about... it doesn't bother me, it's not anything important to me. That's why when I look back... there is no doubt that's what it was. I just didn't care; still loved the life, but just didn't care and to some extent, it was almost like saying, I lost the weight for you and now I'm going to gain it to spite you. Plain and simple truth.

Researcher's Journal Excerpt

I am reminded of Hugh Prather's words that go something like: When I say I don't care, I'm not being honest. Because if I didn't care, I wouldn't spend so much time in the bathroom grooming. But this story opened my eyes to the kind of I don't care because I'm hurt and when I'm hurt, do I do more hurt? It sounds like he was hurting and kept filling himself up with the pain. Would that be right? I'm full of quotes today ... C. K. Lewis says "I don't stop eating when I'm full. The meal isn't over when I'm full. It's over when I hate myself."

Michael

Probably how I felt about myself. I didn't feel good about myself. And I think that's what basically contributed the most to my eating disorder ... I just did not have any self-esteem or self-awareness.

Researcher's Journal Excerpt

This is a direct response of the importance of a positive self-concept.

Chris

I would say a mix... I don't think I had trouble or obsession at the time but really when I started losing weight... it actually first started when ... my family, they used to work in Bolivia... decided to move there for five months... It was important for them and I had a great experience... [I was] a 12-year-old and I think for me, I was alienated more so there just because... I didn't know the language really well. I just had trouble connecting with people. Really I felt kind of alone ... while I was there, I started losing weight. It wasn't like obsessive, but then, that's where I see that kind of trend sort of start... you mentioned personality. I think that's part of it. I am more of a, ah, I'll say a

little more of an introspective/introverted personality ... I think a lot of the time I just didn't have like the energy... I still kind of struggle with this, having the energy to... assert yourself. And when you are a teenager, that's like kind of a hard thing. So I think I tried to work around it. At some point... an outlet seems kind of nice.

Researcher's Journal Excerpt

I have focused on communication... I remember in a nonviolent communication training, the instructor said to me, sometimes when we are learning to speak assertively it comes across as aggressive... it's hard to go from not having a voice to finding your voice but not knowing how to voice and when it comes out wrong or is misunderstood, oy! I just want to crawl back inside my shell or bury myself deep in a good book.

Edward

I think the eating disorder mostly started due to some sexual abuse I had at age 10... I think that was my way of trying to cope and get control back with my body... I think it was just to feel kind of empty and that was kind of reflecting, I guess more or less, my emotional state at that time. And so, I mean, yes, around, as I moved through adolescence, I was influenced by how I should look or how others told me I should look. And so, the over-exercising definitely was in a way to try and fulfill or fit into the male ideal that society had. Um, all the while struggling with self-identity ... I think the way I would word it would be I am just unfortunate to have this specific genetic trait and so given the right environment, it just kind of happened. And so that's how I've always kind of wanted to think of it.

Researcher's Journal Excerpt

Is feeling empty the same as feeling numb? I'm not sure I understand how his reasoning shifted from wanting to feel empty to wanting to look a certain way. I wonder what the impetus was. A girl? He wants to think it is a genetic issue, but he is also saying he was sexually abused and influenced by a male ideal – again, I wonder if some of this is influence of therapy. Maybe he is buying into the messages of why some people acquire an eating disorder and he is trying to make his experience fit into those ideas?

Question 5: What cultural and/or ritualistic eating patterns established in your family of origin's household might have contributed to your eating disorder behavior?

Scott

I can remember ... [my mom] would buy like a whole box [of snickers] and she would put them in the back of her headboard. She had a big huge waterbed and it had like a compartment. I found 'em. I'd eat one and go back and get another one. Of course, she knew the count and she never said anything to me, so she ended up, I remember we had a big upright freezer and she'd lock 'em in the freezer, and I discovered I could take a butter knife, lift up on that lock and instead of getting more than one, I would get one and then lock it back, and probably go back 2 or 3 more times like in a very short period of time. In fact, I knew mom knew those were gone because she kept count of, she knew how many she ate. She wasn't dumb, but she never said anything. She never said a word. I don't ever remember her saying, it's like I said, she never said no.

Jay

Not really. I come from a classic middle-eastern, middle European Jewish family. There was twice as much food as anyone could possibly eat, you know.

Researcher's Journal Excerpt

My mother would never let me restrict. How did he get away with that?!

Casey

I come from my mother's side a German family and we know how to eat as Germans, you know, so, um, my mother was a good cook and she would always put good food on the table and I used to joke around, even if I would go to Europe, like ski trips, and once, coming into France, all these little portions of food, and as soon as I cross the border in Germany, big piles of food. I know I think my heritage to some extent, my grandmother when she was alive and I mean in that period of time, when I first got up to 290, not her fault, my own fault, but I was laid off from work and living with her and my grandfather out in Oregon and she fattened me up real good during that period of time not because she wanted to, but she took care of her grandson. So, there are some cultural aspects of that, you know.

Researcher's Journal Excerpt

This background resonates with my upbringing. My mom would start putting food out on the table and in unison, we would all cry out, "there's enough food here to feed an

army.” And then, we would proceed to eat ... and save room for dessert! Funny, I don’t remember leftovers.

Michael

I think the one thing about eating is there was no structure. You know, um, you were pretty much left on your own to cook your own meals, and come up with your own food and stuff. And, um, it, there was no structure. We didn’t eat dinner together, um, we didn’t have meals together, you know. Our food, we had food in our house, but a lot of time, the food was bad. So, like my mom would send me into the garage to get food...

Researcher’s Journal Excerpt

I am understanding structure from my current schedule. I feel like I’m on a different schedule every day, often eating on the run, alone...

Chris

[My mom is] a professor, but she’s also a dietician. She’s not really from a clinical aspect ... Not eating disorders, but about food and nutrition... I think in a way it was kind of ingrained at an early age, this is something important [nutrition], something to think about... there was nothing like [ritual]... I never, even in my eating disorder, there was never a food I would never touch.

Edward

I would have to say I didn’t pick up anything as far as my family background. Um, I would say that my family is the least cultural people ever (laugh), so I would say no to that [idea].

Researcher’s Journal Excerpt

I wish I would have asked him more about that – what did he mean “least cultural people ever?”

Question 6: How did other cultural issues contribute to your eating disorder behavior?

Scott

The general public does not know, even though we have such a huge obesity issue, not only in the US, but worldwide, that the term bariatric is becoming more relevant. You know, 5 years ago, 5-10 years ago, nobody knew what that term was, but it’s becoming part of our English language and worldwide language ... It’s society, you

know, and it's fast food, you know ... I think it is awesome that ... restaurants are trying but it is all about the all mighty dollar ... I truly believe that grease or whatever they use is very addictive ... Not only the addictiveness to the food, because I will say McDonald's is very addictive, ... but the ease of it.

Jay

[no comment]

Casey

I can't think of anything specifically.

Michael

You know I think there is in this country a big push to eat unhealthy. That's very much rewarded in this society. If you try to eat vegetables with fruit, then, you know, they are very expensive, um, they are not always, you can't always eat when you get 'em. You know, foods that are bad for you happen to be very cheap, you know, they tend to be very cheap. The problem with that is if you have an eating disorder, you don't spend \$3 or \$4 at McDonald's. You have to spend for one meal \$40, you know, in the end you are paying a lot more even though the food is really cheap, you know what I'm saying? Because you can't control yourself when you are eating this food ... I watched cartoons growing up and they had all these commercials for sugar-coated cereals, and cookies, and McDonald's and stuff. I mean, as a kid, you don't think that this stuff is bad for you. You just see Ronald McDonald and oh, I want to go to McDonald's. It brainwashes you... Maybe it's not the main factor ... I think the TV influenced me a great deal. I would consider myself from maybe when I was 5 or 6 to I'd say about 13 when I was totally addicted to TV. That's all I did was watch TV. And then when I hit about 13, I got sick of TV and I didn't watch it anymore.

Researcher's Journal Excerpt

This really resonated. My grocery bills are outrageous for one person but when I look at my shopping cart it's all fruits, vegetables and protein. I should be getting a reward in being fit and healthy ... well, I am healthy.

Chris

I was never teased in Bolivia ... honestly, being overweight is sort of a compliment, do you know what I mean? 'cuz like if you can afford to be overweight, then

you are in a good spot ... [being overweight in Bolivia] doesn't have the same negative connotation that it has here [America]. But, I found this kind of weird ... that was my first time exposed to ... that degree of poverty and I think ... in a sense ... I felt kind of guilty about coming from privileged. In a way being overweight or something like that in that country it also means status. So, I think I felt uncomfortable in a way about my privilege when all the kids I met there, it was not the same. And it was kind of juxtaposed ... I can't really say whether that caused [eating disorder] but you know, maybe it influenced it in a way. Who knows? Because, so much of it is subconscious. But, you know, also, at the same time, in the U.S., here at home, ah, I also had to deal with the teasing and stuff like that. So, two very different, I guess, vantage points from Bolivia being, you know, feeling kind of guilty about it, and then, in the States, for being teased by it.

Edward

Around age 16, there's that huge movement of, you know, this is bad food and, you know, do this and you'll live a better life type thing, and so I definitely grabbed a hold of that and used it to, I guess, let the eating disorder have more justification. Because the message that I guess society was giving me was that an eating disorder wasn't harmful. It was actually what it was supposed to be and, you know, I was a winner. Like I was the one who weighed the least, and this and that, so according to all of those messages, I was a winner out of everyone. Um, that was kind of the message that I had gotten. Not that it was a competition, but you know, I'm definitely a person who wants to follow directions and you know, please. And so, going through health class and being told to do this and that and then, watching stuff on the news, this and that, um, you know, I definitely took it all in and was just like, okay, I have to do everything they said and just overdid everything.

Researcher's Journal Excerpt

It's been really interesting hearing two points of view. Scott and Michael talk about the ways society promotes food, and that has developed into an obesity epidemic, while Edward and my own perception seem to be more around being rewarded if you are thin. And if you are thin and good looking, well, I think more doors open for those folks...

Question 7: What prompted you to get treatment?

Scott

I knew back in '08 ... the last time I was in the hospital... I have to go someplace. I have to or I am not going to be alive. And I truly believe that if I had not come [here] when I did, within six months, I would have been six feet under; I wouldn't be here. I wouldn't be breathing. I believe that in my heart because walking in the emergency room with your oxygen level at 30-40% ... I am really surprised that at that low level, you would be [walking].

Jay

Actually believe I had an episode of orthostasis. I passed out in a class. I was taken to emergency room. I was put on valium at that time for my panic and anxiety. No diagnosis was made of eating disorder. All of these things we are talking about occurred prior to... DSM III... I developed some social network that was positive for me and stopped my exercising behaviors at that time. Um, I still had exercise desires I probably still engaged in but the intensity of the behaviors lessened ... I was actually finally getting in a healthier place. I lasted about 3 months, maybe, in medical school ... I became depressed ... at that point was pretty much at loose ends and because I hadn't graduated college ... what I was able to do was establish a set of connections ... I ate because I loved her and I trusted her and over the course of about 2 years got up to a weight that enabled me to return to medical school and to restart my career.

Researcher's Journal Excerpt

Is there a way to take Jay's treatment and incorporate it into an institutional setting? In a sense, he really healed on his own terms and at a pace he could withstand. I wish it for everyone in this position.

Casey

My doctor was really riding on me and he is a friend of mine, too ... one of his ... assistants in his office had gotten the surgery ... I could see she was losing weight and was like, wow, that really works and she was very supportive ... This doctor is the best ... he was a big influence like I said, the way he presented as being my behavior, I was concerned, was not going to change, so I needed my behavior to be changed, and in this case my behavior was changed by a physical restriction ... that forced a behavioral change.

Michael

Let's see. My mom helped me ... What I think brought me to treatment was, um, when I was in high school, I wanted to go to the prom. I never had a date or whatever. I wanted to take a girl to the prom, so I ended up losing 50 lbs. and I felt pretty good. I lost 50 lbs... . I went to the prom. After that, I started to gain weight. I went to the community college and I slowly gained a lot; maybe I gained like 70 lbs. And my mom put me on a liquid, she brought me ... her job had this thing where if you go on a liquid diet, so I did the liquid diet perfectly for like 5 months and I think I lost like 70 lbs. and I think that was when I was maybe 19 or something like that and um, I felt good ... I was happy, proud of myself. I lost all this weight ... when they stopped giving the ... liquid meals, I really didn't know how to eat. I didn't have a food plan ... they kind of gave you pointers, but they didn't tell you how to do it ... eventually, even though I got into eating healthy food plan, I got my gall bladder out in 1992, in August of 1992, because I must have did a lot of damage to my gall bladder, um, from eating all these fatty foods. From 1991 until, um, 2007, I was abstinent. I was perfectly abstinent. I didn't have an extra bite of food in those 16 years and I stayed abstinent, or whatever you want to call it, stayed on the food plan. And then, in 2007, what happened to me, is [relapse] ... I got abstinent in 2009 basically on my own accord ... but then I met this woman ... And eventually, I kind of got to liking her, and um, but then she pulled away at the last minute and that really hurt me ... I ended up in another relapse in 2010. A really bad relapse ... I ended up putting on 133 lbs... . September 2012 when I got abstinent again ... I've been basically abstinent ever since. Now, my mom just got sick with brain cancer. She was diagnosed, I think like the first week in December. So, I've been back here basically taking care of her and stuff ... my family doesn't really take care of me that well, so I can't get all the necessary foods I need to stay on the food plan. I'm kind of doing the best I can.

Chris

It wasn't really a choice. I think for a while my parents ... didn't really think I had an eating disorder ... I probably did a good job of hiding it or I didn't really believe it myself. You know, but then I think, as it got bad, they were pretty convinced, you know, that's what was going on, and um, I think I switched to a pediatrician who specialized more in this, an adolescent pediatrician. Um, I think what happened, she sort of

moderated it, and I think they started me on an anti-depressant you know set weight goals and stuff like that. And she, um, I came in for a check-up and I think what happened was my heart rate was too low that she basically said it would be unethical if she didn't like, you know, institutionalize me right there.

Edward

Well, that's another aspect of how treatment providers ... absolutely failed on their part ... I was definitely still in adolescence so under my parents' care ... they took me to one of the eating disorder doctors at [a hospital]. My first visit, [the doctor said] 'guess what? You are going to the hospital.' ... I stayed in the hospital for 7 days or so and then I was released. I am pretty sure my parents were not told anything, any suggestions, any recommendations of outpatient treatment or residential... They just brought me home and I did some therapy appointments once a week and went absolutely nowhere in recovery. And so, I didn't officially enter any sort of psychiatric treatment until I went to college. And then, just absolutely fell apart because, you know, it wasn't a local college. I was definitely away and I was definitely having ... even then ... I didn't get treatment because of the eating disorder. I was taken to a hospital because I was having auditory hallucinations ... it wasn't like the eating disorder was being acknowledged at that point. But through that hospital ... they directed me to [a treatment center], um and so, of course, at that stage ... I would never say I was the one that wanted treatment. It was more of like my parents, um, really pushing me along to do that. And so, I ... 3 months [in treatment], and went back to college. I didn't finish that semester, um, and then I basically went straight into residential. I was there for, relatively a short amount of time, but that's when like I had a change in mindset in that I recognized I was no longer in control of my life and I felt that emotionally.

Researcher's Journal Excerpt

Treatment is really similar. Behavioral. Diet and exercise – either getting on a program or getting off one ... I can really see how through diet we “train the brain” and why eating disorders might be viewed in a similar vein as addictions. Oh, balance! Like chasing a carrot.

Question 8: What type of treatment did you undergo?

Scott

It's pretty much what you do. It's not handed to you ... Basically it is diet and exercise ... going to therapy... I get to go to the Y four days a week... and I go swimming; I walk at least an hour in the water.

Jay

I never had any formal treatment for the eating disorder ... about 12 years after the disorder began, maybe 13 to 15 years, that I first understood I'd had an eating disorder ... I was already weight restored ... eating in a relatively normal fashion, whatever normal means. I could go out to a restaurant with friends, I could have nachos, I could, you know, do the stuff that people do socially, have a pizza, whatever.

Casey

Bariatric surgery.

Michael

I went to a primary care treatment [center] ... Group therapy. It was like an all day therapy. It was like, they had food group. They talked about food. They talked about nutrition. They talked about therapy. You know, they talked about different issues. You know, they talked about spirituality ... There was a lot of support.

Chris

I went to the ... Hospital, which really isn't that well equipped for this. It was a terrible experience (laugh). Um, I wasn't gaining weight fast enough and so they actually put a feeding tube in and then they discharged me. And right from there, I went to a Center ... it was kind of in between those – you know, some only take people once they are in a certain state of health and able to focus more on the cognitive therapy aspects and group therapy... . one of those in-between hospitals ... I underwent treatment. At first, I think it was in-patient, then it was partial in-patient, I guess. I didn't spend the night there. Um, eventually I was discharged, went back to school and then, I still struggled so I went to another program at another [center].

Edward

I didn't officially enter any sort of psychiatric treatment until I went to college... I was taken to a hospital because I was having auditory hallucinations ... through that hospital ... they directed me to [center] ... 3 months [in treatment] ... and went back to

college. I didn't finish that semester, um, and then I basically went straight into residential. I was there for, relatively a short amount of time... In the house there was three floors. The basement was the guys, the first floor was college-age girls and then the top floor was adolescent girls. And so, we would eat in the same dining room, and we would see each other and talk to each other, but like group sessions and living, of course, was all the guys. And so, it was definitely, there was definitely people there staff-wise that's all they did was males with eating disorders ... I was in a CBT/ERP program ... Exposure Response Prevention ... The ERP is really the reason I am alive (laugh) in all honesty, because somebody literally worked with me to change my behavior and challenge my thoughts. And it was that mindset that really provided me with the tools I needed to create the recovery for myself, because I learned no one is going to recover for me. I have to do it.

Researcher's Journal Excerpt

No surprises here; participants' responses seemed to agree with my personal experience working in an eating disorder center and everything I've learned about treatment protocol for an eating disorder. Refeeding and group therapy involving CBT/nutritional psycho-educational focus. ERP was a new term. My brain immediately turned it into CBT to try to understand what Edward was explaining. I thought there would be more comfort in treatment for a man in a male eating disorder unit, but Edward wasn't really expressing that being in a group with all men made a difference.

Question 9: Describe your masculine identity with respect to having an eating disorder.

Scott

(Scott was not asked this specific question, but he did speak to his struggles as a man attending nursing school.) All of my instructors were still in that old school frame of mind, and as a man, I had a double whammy on me with my weight plus being a man [in nursing school].

Jay

It didn't effect it much. The thing about having an eating disorder and being a really sensitive guy is that I'm really comfortable in the world of women. Um, I mean, I have always had a very masculine identity. I really enjoy my masculine identity, but I,

you know, I have spent 90% of my time, of my life with women ... Having said that, I have rich male relationships and ah, the core to my rich male relationships, in fact, has been honesty about my eating disorder. In other words the trick with men is always the same, which is that men keep secrets differently than women keep secrets, and ah, men act tough, etc. Being free to talk about my disorder, my eating history with other men has, in fact, done nothing but brought me closer to them and has given them permission to talk to me about real stuff in their lives. So, I would say that, ah, I feel very, very lucky. I have some very close male friends ... when I was lost in the eating disorder, I really didn't. I really only had one close male friend ... It was hard to keep relationships together. But it wasn't about masculine identity or friends at that time. It was just hard to keep relationships together. Masculine identity has never been an issue for me.

Casey

I would say when I was younger it was more important to me to ... want to look a little more chiseled ... as I've gotten older and it's become less of an issue to me ... interestingly enough just the loss of weight, and whether it's a friend of the same sex or a different sex looking at you, ... know[ing] they are not looking at you like a fat guy anymore ... It's not necessarily an issue of masculinity. I suppose it's kind of like a side benefit ... it kind of ties into the masculinity thing as it relates to the weight loss and stuff like that because I could say, okay, well now, you know, I'm 55, I'll be 55 next month, it's like, but you know I don't have any hair on my head like I did when I was in my 30s even, but, you know, at least I don't feel at a disadvantage from a masculinity standpoint because of weight. I feel as though at this point in time, there is potentially a person out there that would find me attractive enough whether it's physically and/or just ... It's about feeling good, feeling good about yourself, as an individual more so than as a male.

Michael

It never really occurred to me, I guess. I never really thought about it. You know, like I realize that there was, you know, I was in a community that was 95% women and that occurred to me. I kind of thought about it from time to time, it never really bothered me or anything. It never got me down or something.

Chris

At the ... Hospital I didn't know anyone else. I was in my room and I could eat in my room and you know, I was forced to be in bed rest. I couldn't move... . The Center ... there was a couple of other guys there, so I wasn't alone. I don't know. I never felt really weird being a guy in a center for eating disorders. I felt weird about, being more self-conscious about being a guy outside of that, you know ... I was pretty up front talking to people. I remember when I was in the hospital, I called ... [a] teacher I used to have for support, some of my close friends knew about it, um, you know, and I was okay with that. You know, friends were guys as well. And even when I went back to school, I was open about to a certain group of people. But I think it is kind of dealing with the assumptions people have about being a guy with an [eating disorder] ... I think on top of it maybe, people feel awkward. They don't know how to talk about it to you and I think that's hard. I don't know what kind of assumptions people have, but I think like I don't know, they might think that guys that experience [eating disorders] are more feminine or they don't, ah, they are totally obsessed with their image. Um, which in a way I think is kind of a vast exaggeration they made for all people with eating disorders whether male or female.

Edward

As far as, like my masculine identity throughout treatment, I mean at [first treatment center] I was the only guy. While I was in the hospitals, I was the only guy with an eating disorder ... part of me was comfortable with that considering, you know, the abuse I had early in childhood, and so, even today, I still struggle with males, um, and so, it was very easy to just let go that I was male and be like, oh, here I am with a bunch of girls. I was fine with that. And so I would definitely say I felt more accepted ... I think in a sense the other males at [the center with an all male unit] also had an eating disorder ... there was this one kid in particular, um, who was absolutely like my guard. He had my back any time and I was very much so thankful for that. I think it was because of him that I really had the opportunity to really work on myself. Because if I didn't have someone to back me up, I would have been absolutely miserable and would have just shut down ... I didn't really care who all was around with at that stage. All's I knew is that somebody was actually trying to understand me and that's really all that I cared about.

Researcher's Journal Excerpt

I don't know what I was expecting for responses to this question – that's probably a good thing, that I didn't have any expectations. Still, I was surprised. I guess, for these six men, being in a group with people that had the eating disorder in common was beneficial.

Gender did not matter.

Question 10: What was your attitude toward treatment like?

Scott

If you have to call a place like this home, it is home ... the staff is wonderful ... I realize any place you are going to be, you are going to have those few bad apples, but at this point in time, our staff is wonderful ... they care. I know they can read me like a book ... I could be having a bad day or at night time having an argument with my mom or my brother [over the phone] and you know they can read me. I can say “no, I’m fine” and they will say, “no, you are not.” What’s going on? ... they force it out of me, you know ... People come here and they expect things to be handed to you ... If you have the money and you want to order out you can order out. I’m lucky I never have money... in a way that does get frustrating some times, not having any money to do anything with, but I think in some ways it is a blessing because that temptation is not there ... the meals have gotten a lot better, we have ... healthy ... choices [on the menu] ... You are here for a reason. We have several ... that are in that bed 24/7 and don’t get up, and I don’t get it. I don’t get the point. There is only two of us here that are fully ambulatory. I do walk with a rollator and I do have that because there is no place to really sit ... I am in the process I’ve been bugging them about measuring from nurse’s station to nurse’s station to know how many feet that is and how many trips it will take to do a mile. I did a 5k in April with ... our social worker.

Jay

Therapy is hard. It’s hard for everybody. It was very hard for me ... my current medical team all knows about my history eating disorder ... I am at that age when they give you a stress test. And my resting heart rate was like 55, or some number like that, and I told them not to ignore that, I said it should be around 60. Well, it’s okay it is 55, you used to run cross country. I’m like, no, no, no, it should be around 60; you know, I tend low because I have had this for a long time. I work hard, I lost some weight, I got

older, things change, I changed activity levels. You keep it in the background of your mind. So, my current medical team is aware of it, but they don't know what to do about it. Nobody includes it in their thinking about me; it is just not existent to my medical team. I have to tell them how to think about it; that's okay they are open to it ... Anybody who goes to the doctor with a low heart rate gets told how great it is and they must be an athlete. That's just universal ... It's the nightmare of the field ... I was told Michael Phelps has a low heart rate. He eats 12,000 calories a day. If you eat 12,000 calories a day and your heart rate is 42, okay, I'm with you. His heart is twice as big as yours.

Casey

I was scared to death to do it ... the time leading up to it ... relay a quick story ... the job I was working on was slowing down and actually gave me a winter window of opportunity, so I scheduled my surgery for two days after Christmas. Then, in November, (slapped hand lightly on table), I had an opportunity to do a job ... (slapped hand lightly on table) and it was like, something that was handed to me on a silver platter through a referral, and I was like I want to take this job but because it was going to work through Christmas and into February ... I realized that I wanted to take the job because partly, it was enabling me to push off this surgery. I have a certain level of medical anxiety that I suffer from, just things of worrying about health and stuff like that...I just had an excuse to push this surgery off for two months and as much as I was into the program and losing some weight and stuff, I took advantage of it and worked the extra two months. But then all of a sudden, and then, I was hesitating rescheduling it, and one day I just said, (slapped hand on table) I'm going to do it (slapped hand on table). I'm going to reschedule surgery (slapped hand on table), I rescheduled it for February 27, and I said I told the client (slapped hand on table) when I'm done with this job, I'll be out on medical leave for a month (slapped hand on table) and then, so we all knew everything that was happening. And then, it was all good and all of a sudden, now it was two weeks before, and I'm looking, Oh God ... I don't know why I was worried. It's just a weird, it's an anxiety that I have about hospitals (slapped hand on table) and medical stuff and four days before, on a Friday; I had the surgery on a Wednesday. On a Friday night I came home from work and I said I'm backing out. I literally told myself, I'm not doing this, something's going to go wrong and uh, I could lose the weight...I literally paced around

the house ... I've got all these supporters and I have to think about what I'm going to tell each one of them; why it is a good idea for me to back out, and I just got myself into a panic attack. Now, I do take Xanax for anxiety. I take it twice a day. And I just kind of, over the course of the weekend, I climbed down off the ceiling, and Monday morning I was like okay, I'm doing this. And I'm very man of faith and I prayed to God and, God don't let me do this and fell to my knees in prayer, don't let me back out on this. And Monday morning, I was okay with it. Was I scared when I went in on Wednesday morning? Yeah, I was, but I was just accepting of it at that point in time ... But anyway my attitude, even after the surgery, I was pumped up about it but then it went bad, because I was like something's not right. And my doctor just kept encouraging me and said it will work itself out. It was just problems with inflammation so he put me on anti-inflammatories (slapped hand on table) but from that moment is when I started saying I better trust it (slapped hand on table).

Michael

Good ... If they told me to take my clothes off and dance naked in the street to be abstinent, that was exactly what I would have done. So, I was very willing to do whatever they told me to do.

Chris

It got better; it was worse at the beginning, though... I'm pretty sure [Center] had to make new rules because of me ... I was creative and stuff in ways of hiding food and whatever, which sounds ridiculous right now ... but really, it is kind of unbearable because the whole time you are watched, you are scrutinized and no matter what you say no one will think you are sincere. They will think you are hiding something and sometimes you are, but just the fact that you are always, ah, I don't know what the word is I'm searching for, you are just never trusted and so one thing that comes to mind ... when I was in the ... Hospital, there was this nurse and I couldn't stand her. And so I had some friends, and they came to visit me and one thing they did was take one of those gloves, Playtex gloves, and filled it with water and drew a shape on it. It was just this fun ... toy and I just kind of had it under my bed. Anyways, this nurse found it and she's like I can't believe you are having something like this; and what she was accusing me of was using that to drink the water before they weigh me. Which I never did, I never intended to

do, but you know, I couldn't even defend myself about it because anything I could say, you know, isn't going to be taken at credibility, and when you are 13 or 14 years old, which I was at the time, nobody is going to listen to you. Um, so I think it is terrible and I think I even like, because I was mean to all the nurses. There was a lot of them. I even wrote a letter saying that this how I was and I know it was just your job. I'm sorry I treated you this way. But honestly, like I left after that and now looking back on it, I don't know why I wrote that. I think they were mean. I think they could have done a better job and like I'm dissatisfied in the way they treated me and um, you know, so I think health care teams could do a much better job. And this also goes to the [other] place [went for treatment] ... People who do the group therapy sessions, they don't even look like they want to be there. They're probably throwing in residents that don't want to be there ... they are just trying to get their credit or their part of a rotation done. Um, and I don't know, it's bad because you go in and you are already put into a box of what people say what people with eating disorders is like, you know, or what their book says, or something like that. Um, so for me, I think that was the hard thing. It did get better. [Center], for instance, was a much better place to be and maybe because there is more cooperativeness and maybe because at this point we have to give you some, um, freedom. We can't watch your back all the time because we have to transition you, so it was better at that point. But, you know, if there was a time that I could have done that by myself, so I think I needed to be watched but it could have been done in a better way.

Edward

I can literally remember my mindset. My last day at [Center], the first time [treated], I was like ... I need to get back to college so I can do behaviors again ... that's exactly what I did (laugh), um, so I think I got caught up on it. I was down in college with my sister and I was writing a letter to a friend and I had just mentioned like having trouble with behavior ... I don't know if I would be alive if I wouldn't have fallen asleep and left it on my desk for my sister to read the next morning because basically that day my parents picked me up took me back to the hospital. And so then I was shuffled into residential at that point ... I would say my first ... go around ... in treatment was let's behave the best to get out the soonest to go back to the eating disorder, um, and it wasn't until I was in residential where, you know, I was definitely worried about my family

because, um, how I was struggling impacted them a lot. And so, I really started recovery with the mindset of I'm recovering for my sister, I'm recovering for my parents and that gave me the footing, I guess, to start really working on myself and eventually that developed into the perspective of I need to recover for me as well.

Researcher's Journal Excerpt

There is such a dichotomy between the participants with anorexia and those with morbid obesity or binge eating in how they look at treatment providers. Scott's like "I would dance naked if that's what they told me to do" and the others are like, they don't even get what's going on, they are all incompetent. Could that be the anorexic ED voice finding excuses/ways to not get better? Or is it a greater stigma around obesity ... individuals will do anything to be thin, to belong, while anorexics are fighting to stay thin, but have a hard time judging when they are thin enough.

Question 11:

What type of medical care and psychotherapeutic interventions were received?

Scott

This is going to be a life-long struggle ... I had lap band surgery and I have not had the success with it that I wanted. I know the last time I had anything put in the band was a year ago ... I am at my max ... the same year that I had the surgery I was diagnosed with Chiari Malformation ... Chiari Malformation is ... where the end of the skull where you have your cerebellum goes down into the spinal column. It's something congenital. You are born with it, and they don't find out you have it until there is a reason to do the MRI of the head and neck. And I also have what is called a syrinx, which is a fluid pocket that is in the spinal cord ... it's not related to weight ... I'm going to have to have surgery, brain surgery, it's decompression surgery ... I have a huge history of cellulitis.

Jay

Half-way into sophomore year of college, um, at which point I had what was diagnosed then as a panic attack. Actually believe I had an episode of orthostasis. I passed out in a class. I was taken to emergency room. I was put on valium at that time for my panic and anxiety.

Casey

The [bariatric] surgery is typically... on a Wednesday... 24 hours later they give you a radioactive fluid to see if you are passing fluids through your stomach. And if you are, they give you liquids like soup, just a broth and Friday you go home. Wednesday, went downstairs, took the stuff, uh, it ain't going anywhere. Freaked out ... I, you know, the ladies who were taking care, the nurses and stuff, I really tried to go out of my way to not be a pain in the ass to them because I was like these people, they get so many people to ring the buzzer complaining about things. I have to be gracious about the caregivers that I have and despite the fact that my discomfort, trust in God that I was going to get through it. It took 'til Sunday. Yea, um, once I got into the program, it was really only medically supervised, seeing a doctor or seeing a nutritionist for that, course, um, but they don't. They do like group sessions for the psychological side of it, you know. I, once I got into the program, I started to get pumped up about it. You know. I would go into a room with a bunch of fat people and maybe a year from now we all will have lost some weight, you know. I never, I don't know, I just never really felt that I tend to be somebody who feels as though I can get myself over my own psychological problems so I tend not to seek professional help.

Michael

It was group therapy.

Chris

I'll try my best to remember. If I go in chronological order, uh, so at the hospital it was strictly re-feeding ... [and] bed rest. And in [the next treatment center], it was more of a group-based. There was a group therapy; I don't know the name for that, and refeeding, meals together, stuff like that. [Last Center] was where the most I guess real therapy was. I know they did, what is it called, DBT? ... they've probably changed it a little bit since then but it is the same kind of focus. I think it was at first intensive out-patient; at first, I was there every day or at least 5 days a week or something like that and then, eventually it was a, you know, less.

Edward

ERP ... Yeah, I would say, yeah, I don't have much to add to that.

Researcher's Journal Excerpt

If I could do it again, I would ask this question differently. I really don't have knowledge of co-morbidity for each of these guys – well, I have some, but not specific. I really stayed focused on the eating disorder, but am left wondering about comorbidity factors.

Question 12: How would you describe yourself now?

Scott

I think it is good to have support ... This is going to be a life-long struggle ... I really think that the ultimate goal to get to the point where; one of my goals is, when I go home, within six months of going home, I want to be back to work. I'm not going to be on disability the rest of my life ...

Jay

I am pretty healthy. I feel very healthy. I feel massively recovered, which is not to say I cannot recover more ... If I'm going to build muscle mass, I'm probably going to gain some weight so that's like, okay, that's what's going to happen; that's what should happen That's my understanding of the basic body physiology which is utterly different than it would have been during the disorder. Um, free choice, um, you know, ... [if] there's a piece of cake, you have a piece of cake ... You drop that craziness of thinking that if I eat one piece of cake it will make me fat. Those pieces are just not there for me. I loved that they are out there, but I remember them, the crazy thoughts, the pride over the restriction and all those things. When I look at myself now, its just not there ... I'm trusting it and I'll stop when I'm full.

Casey

I mean, very content from the standpoint of ... pleased from a physical standpoint and motivated to continue on that path you know that I'm on. I've got some other business related challenges in my life that are causing me a lot of stress right now, um, that sometimes tend to over weigh that those feel good situations. I am in a situation where my partner is retiring and its probably not going to be a very good break up of our partnership when it happens. And that's got me kind of stressed out right now. It affects my feelings about myself sometimes.

Michael

Yes, I still suffer from [low self esteem], but I'm a lot better because ... I continue to be in therapy. I continue to put myself in therapy ... I'm not fully there yet. I've still got some problems that I've got to work out with that, um, but I'm a lot better than I was.

Chris

I really don't think there are any issues and you know whether it is body image or ... There's always some things I can get help on. I've been on anti-depressants essentially since I was 13. I've gone off at some points, but you know over a year I usually feel myself feeling like I need to go back on them. Um, so I still think there is struggle, but I don't know if that's so much a factor of that's sort of how I am wired and given the stresses I am putting on my life. I feel like I know it's better that I use those. With eating and excessive exercise, there is no problem with that, um, but if, you know, little things I struggle with, that are social or of trying to feel included or being listened to, yeah, there's still some of that.

Edward

I'm definitely still learning a lot about life because my eating disorder basically was from age 10 to age 19. Um, I didn't really develop a lot emotionally and like identity-wise. And so I've been, you know, slowly progressing and understanding more about me and getting back to normal life for a 21 year old. Um, but like I said, I'm still learning.

Researcher's Journal Excerpt

Jay, Casey and Chris really lit up talking about their current health. I felt they were sharing a sense of accomplishment – I beat this thing and I'm proud! I felt inspired!

Question 13: How has your view of yourself changed?

Scott

It really scares me to go home. I think it is because of the issues back home... My mom has not seen a picture of me since I've been [here]. She has not seen a picture of me in 5 years ... And I cannot foresee, I have never been out with friends. I have never been to a bar, I have never been out with friends, never had a girlfriend, never had a relationship, I can see myself being in that aspect of being home all the time like what she is used to if I'm not working or if I was at school not working physically I was home.

That is why I try to tell her not to expect the same Scott home because you know, at that time, I wasn't able to do things. I am able to do things now. I've never experienced what I guess you could say a 20-year-old will ever experienced. And here I am turning 40 this next year. I don't want to be like a 20-year old but you want to experience some of those things you know.

Jay

I am pretty healthy. I feel very healthy. I feel massively recovered, which is not to say I cannot recover more. Just so you know, that's how I hold this. I hold this as massively recovered, but it doesn't mean I can't recover more. I'm part of a group of 70 professionals who have history of disorders, we communicate and meet every year. Um, we work really hard... I feel very, very gratified to be in recovery ... I feel lucky to have recovered. I feel very good about it. Um, I had a different understanding of body, size and shape.

Casey

In a positive way because as I said I always, I shouldn't say always, I sometimes wondered when I walked into a room, whether it was in a professional situation or not what were other people thinking about you because you are morbidly obese and fortunately, I felt as though my personality at times could overcome a lot of that because I have a very, fairly good upbeat personality ... but then you always wonder, ... [if] I'm meeting with a prospective client and they are looking at me and going, 'I don't know if I want to hire that guy because I'm not even sure he could walk up the stairs to the second floor of my job.' You know. So, now, I don't worry about things like that. It's been very positive in terms of what my confidence in myself, and what I can do physically, compared to what I could before.

Michael

The whole philosophy around food totally changed ... My philosophy is that it could do a lot of damage to me if I let it. You know, it can definitely kill me.

Chris

Okay, since then, I mean a lot. I think, I don't know about the other people you will be interviewing but I think there is a much, I might have a bigger span of time from now until when I had to go through treatment, so its hard for me to pinpoint how much of this

is actually due to treatment, um, but I think I have a much healthier outlook about myself. I think I'm better at knowing my limits and not feeling bad that those are my limits. You know, I have a much healthier understanding of body weight, obsession, and you know, proper or better ways to manage stress and um, you know, getting to feelings and stuff like that. Um, you know, you see everyone finds a way of dealing with stress. It all depends on whether it is a healthy outlet or a destructive outlet, so it's transition to that healthier outlet. Um, I mean I think it is definitely ... the experience has helped me to relate to people struggling with different things. I think there is a place of empathy that came from it. Sometimes when I think about back then, I don't really even think of it as me anymore 'cuz I don't know, it seems so long ago and so like different from how I experience the world right now.

Edward

I would say my view of myself went from not being a person, not having ... the disconnect between my body and ... my head ... I would always say I don't want this body because of what happened to me ... I still want to have ... the happy-go-lucky attitude ... it definitely progressed from not wanting to be a person to then, around age 16, wanting to be like the super man or something ... I had hopes of being an officer in the Air Force and you know, I really only wanted that just to ... prove to others that, you know, I was capable of being someone. And then, it developed into just wanting to be peaceful about myself. Wanting to accept both my body, my thoughts, my perspectives and not wanting to have a struggle with it anymore.

Researcher's Journal Excerpt

Acceptance – I don't know that I got a clear idea of how perspectives shifted from holding onto the eating disorder to acceptance. I know "tool" and relationship had a lot to do with it and both seemed important.

Question 14: (Depending on the situation.) How do you know or when will you know you have recovered; or, what keeps you in maintenance?

Scott

This is going to be a life-long struggle.

Jay

It really had to do with behavior and activity. It had to do with I could do whatever I wanted to do. Concerns about food, body, size, and shape did not determine where I went, what I did, who I was with, when I was out, I didn't have to control myself in certain ways in order to feel comfortable, the anxiety would not creep back in if I did x, y, or z, um, the sense to be in control in self went down to whatever human norm is; it was really all those things. Clearly, I had to be at a healthy weight first. Getting at a healthy weight was most important. This I have no question in my mind, healthy weight absolutely precedes everything. I had to absolutely have no behaviors. Everything I just said to you came after these things. #1 was healthy weight, by healthy weight I mean strong enough to do the things I needed to do without fear that my weight would negatively impact me. I had to not have behaviors, I had to not restrict in particular. I could exercise as long as I made up for the calories I burned. But I had to eat three meals, have my snacks. If I went out for pancakes, I went out for pancakes. I had to be able to eat. Those were the absolute prerequisites. After those, I had to be able to live with basically the community be with other people, do what they wanted to do enjoy the things that they put out there not have to have it be my way based on whatever craziness was going on inside my head. And then I think the ultimate measure of my own healing was my ability to have this conversation, to take my own self-knowledge and to be able to utilize it for the good of others and to accept the feedback from others about whether it was working or not. Those are the stages that I see.

Researcher's Journal Excerpt

Behavior and activity changed organically via being in relationship with others. He was able to network and through friendships, had a sense of belonging to this group, his behaviors changed – he was busy working on a play and falling in love – reprioritized, found purpose.

Casey

I'm in maintenance. I'm not gained any weight because I didn't really eat enough that day. I should be eating three meals diligently instead of sometimes only two. That's not how I'm supposed to do it ... Just probably being busy at work, which is the same thing that before could be triggers to sit there and graze on stuff all day long. It has kind of a

reverse trigger where I don't have a physical striving for food, so therefore, when I'm busy, I don't eat. Kind of like the exact opposite, you know, where as before I'd go, I'm hungry, and you know go to the snack machine or whatever and sit there and pump junk food into me. Now, I'm busy and I don't eat ... so it's kind of a weird deal that the same things that triggered being busy, emotional distress, that triggered eating, now can sometimes trigger not eating.

Researcher's Journal Excerpt

From one extreme to the other? I know that eating disorder diagnoses can change. Is Casey becoming anorexic or bulimic? What happens when he meets his goal? Will he stop and maintain? Find balance?

Michael

Dealing with my emotions ... That's the key ... That's the ticket... the other thing I've done, too, to supplement my spirituality. I think spirituality is another important factor ... meditating regularly, doing Mindfulness. I'm reading a lot of Buddhist literature.

Chris

When I was really malnourished, the hunger cues don't work right anymore... You actually have to be at a healthy weight for a while and well-nourished for those to actually really work again, and then for your mind to trust it and go with it. Um, so for me, right now, I just try to listen to my body, you know. Um, when I was in my eating disorder, I did excessively exercise. I think I'm still really active but now, like, you know, I do it in a healthy way. Um, and you know, I listen to my body. I won't push myself to a point beyond exertion or exhaustion, you know. I know when to stop.

Edward

I would say that the "major behaviors" like the purging, um, whether it be throwing up or the over exercise, I've definitely not done that since residential. I still struggle with the restriction some, but I definitely have been maintaining, um, my health and weight, such that I don't slip back and relapse. And so, I would say I lot of the motivation behind the eating disorder ...was regards to like the body image and wanting this and that, I don't have that motivation anymore, and so that helps me not do the more aggressive, I guess, behaviors to change my weight and body size and that stuff.

Researcher's Journal Excerpt

Jay and Chris felt recovered from anorexia nervosa and Casey is really close, although I wonder about the reverse effect. I am probably being oversensitive to the situation because my awareness of eating disorders is so heightened. Edward sounds like he is on a good path toward recovery. Michael has surrounded himself with support in the event he relapses. He's been abstinent before for a long period of time and I got the impression that he believes in himself to be able to do that again. For Scott, he believes this will be a life-long struggle, but seemed determined and motivated.

Question 15: How much of your recovery do you attribute to the treatment process?

Scott

The thing is a place like this, it's a nursing home. We are not here because insurance, whether it is Medicaid, Medicare, private insurance, they are not going to pay for bariatric. It is your secondary and third conditions why you are here. You're here either because of respiratory issues. You're here because of a history of cellulitis, whatever it could be. You're not here, yes you are here because you are a bariatric and you need help taking care of yourself, but in insurance ways, you are not here for bariatric.

Jay

All depends on if you include my wife as treatment ... I do believe if left on my own to try to fend for myself and to have fed myself, I would have been unsuccessful. I think I had been trying and failing, so I think if we include being fed by my wife, I think most of my recovery is related to treatment.

Researcher's Journal Excerpt

I wonder if the way I framed the question was leading, because I really saw most of his recovery being related to relationship. That was the treatment. I think he does say that.

Casey

90% of it [to the surgery] and the other 10% probably ... I've had a lot of very supportive people. You know, friends and friends in church that have been extremely supportive and that's been a big help. I mean treatment is a big part of it, but the positive reinforcement from other people is a huge ... Ah, actually I said 90% the treatment itself,

but right now, I don't know, you know maybe the treatment is half ... I can get up and look in the mirror, you know, and feel good about myself.

Michael

I would call it maintenance. I was in maintenance for years and years and years. So, I think the other thing is that being in maintenance for 16 years, um, does something. It kind of makes you realize, it kind of brings you to another level. I'm not trying to toot my own horn or anything ... it kind of makes you see when you're not doing what you're supposed to do. You know, you can't lie to yourself when you're not doing what is right.

Chris

Knowing and also accepting... I wouldn't... if I hadn't gone through treatment, I would have never recovered. I could not have done that on my own. So, you know, it has to take credit, but I can't tell you if it a specific therapy was better. I think I had a good therapist. I think I was lucky to have a supportive family. Um, I think those were the two biggest things ... I think the other stuff was a little necessary where they had to take control away from me and eventually give it back, um, but yeah, I think the biggest thing was having a supportive community. Um, and those who are willing to listen to your story and hearing what you have to say and not like, you know, not already painting a picture of you, but there to help.

Edward

I also have some struggles with OCD ... ERP is also used with that where it would be um, more like, for example, I absolutely hate it when picture frames are off kilter. These are pretty good. An example of work with ERP would be like I would go around the residential house and just like tip every single frame and not correct it and that was like the exposure part. And so, you know, it was just the ERP was definitely something that no one else had ever done with me and really working along that spectrum like I said of the behavior instead of being like you're doing, you're not, because, you know, that never worked for me. Um, I would say that more along the lines the spectrum of the behavior was really what helped ... I've tried developing a friend network who would like support me ... I mean in all honesty, my mom I don't think really told my grandparents much detail and I know my dad did not tell his parents at all about it. And so, even within the family, it was really, kind of like kept in a jar, in a sense. And so, I've really learned

to really utilize all the support I could from my treatment providers, um, and you know, not relying and being dependent on them but just knowing they are there to help me, um, and really reaching out to receive the help. That was important in that relationship was that intellectually I knew, oh, they are here to help me, but actually allowing them to do that is a different thing.

Researcher's Journal Excerpt

I think I did get a good picture of what recovery looks like and the challenges one has to face to get to that point. I really appreciated Chris' sigh of relief when he shared he was just glad to get to the point of no behaviors.

APPENDIX E

RESEARCH AND INTERVIEW QUESTIONS

Research Questions	Interview Questions
<p>What was the etiology of each participant's eating disorder?</p>	<p>What has been your eating disorder experience starting with how it began?</p> <p>How do you make sense of having an eating disorder?</p> <p>What do you believe impacted you most in your development of an eating disorder (Media? Peer relations? Family? Personality trait (e.g., low self esteem, body dissatisfaction)?</p> <p>What cultural and/or ritualistic eating patterns established in your family of origin's household may have contributed to your eating disorder behavior?</p> <p>How did other cultural issues may have contributed to your eating disorder behavior?</p>
<p>What prompted participants to get treatment?</p>	<p>What prompted you to get treatment?</p>
<p>What is each participant's experience of having sought and undergone treatment in a heterogeneous or homogeneous environment?</p>	<p>What type of treatment did you undergo?</p> <p>Describe your masculine identity with respect to having an eating disorder.</p> <p>What was your attitude toward treatment like?</p> <p>What type of medical care and psychotherapeutic interventions were received?</p>
<p>How were participants' perspectives altered through treatment?</p>	<p>How would you describe yourself now?</p> <p>How has your view of yourself changed?</p>
<p>What interventions inspired participants to shift their perspectives regarding eating disorder behaviors?</p>	<p>What keeps you in maintenance?</p> <p>How much of your recovery do you attribute to the treatment process?</p>