

*Portfolio submitted in fulfilment of the requirements for the  
Professional Doctorate in Counselling Psychology*

*An Exploration of Men's Experiences of Motivation to Change in  
Relation to their Journey with Anorexia Nervosa.*

*Barbara Tresca*

*City, University of London*

*Department of Psychology*

*June 2018*

## Table of Contents

I.	List of Tables, Figures, and Abbreviations	7
II.	Acknowledgements	8
III.	Declaration of Power	9
IV.	Preface to the Portfolio	10

### **Section A: Doctoral Research Paper**

An Exploration of Men's Experiences of Motivation to Change in Relation to their Journey with Anorexia Nervosa.

<b>1. Abstract</b>	<b>19</b>
<b>2. Chapter One: Review of the Literature</b>	<b>20</b>
<b>2.1. Overview</b>	<b>20</b>
<b>2.2. An Outline of EDs and Recent Figures</b>	<b>22</b>
<b>2.3. Literature Review</b>	<b>24</b>
<i>2.3.1. Research conducted on EDs: a selection of topics</i>	<i>24</i>
<i>2.3.2. Men and EDs: Brief history and recent media presence</i>	<i>28</i>
<i>2.3.3. An overview on gender conceptualisation in relation to men and EDs</i>	<i>30</i>
<i>2.3.4. Treatment</i>	<i>33</i>
<b>2.4. Motivation to Change</b>	<b>37</b>
<i>2.4.1. Intrinsic and extrinsic motivation to change</i>	<i>37</i>
<i>2.4.2. Relevance of motivation to change for EDs</i>	<i>38</i>
<i>2.4.3. Relevance of motivation to change in EDs for counselling psychology</i>	<i>39</i>
<i>2.4.4. Research on motivation to change in EDs</i>	<i>40</i>
<b>2.5. Rationale for the Current Research to Lead in to the Study</b>	<b>45</b>
<b>3. Chapter Two: Methodology</b>	<b>46</b>

<b>3.1. Introduction</b>	<b>46</b>
<b>3.2. Research Aim</b>	<b>46</b>
<b>3.3. Rationale for Using a Qualitative Research Paradigm</b>	<b>46</b>
3.3.1. <i>The limitations of quantitative methodologies for EDs</i>	46
3.3.2. <i>Suitability for qualitative research</i>	47
<b>3.4. Ontological and Epistemological Position</b>	<b>48</b>
3.4.1. <i>Ontological stance</i>	48
3.4.2. <i>Epistemological standpoint</i>	49
3.4.3. <i>Epistemological reflexivity</i>	50
<b>3.5. Methodological Considerations and Research Methods</b>	<b>51</b>
3.5.1. <i>Methodological considerations</i>	51
3.5.2. <i>Research methodology</i>	52
3.5.3. <i>Consideration of other qualitative methods</i>	53
<b>3.6. Pilot Study</b>	<b>54</b>
<b>3.7. Data Collection</b>	<b>54</b>
3.7.1. <i>Research sample and selection criteria</i>	56
3.7.2. <i>Inclusion criteria and recruitment</i>	56
<b>3.8. Procedure</b>	<b>59</b>
3.8.1. <i>Rationale for using semi-structured interviews</i>	59
3.8.2. <i>Interviewing process</i>	60
3.8.3. <i>Interview schedule</i>	61
3.8.4. <i>Interview recording and transcribing</i>	62
<b>3.9. Analytic Strategy</b>	<b>62</b>
<b>3.10. Ethics</b>	<b>67</b>
<b>3.11. Validity and Reliability</b>	<b>69</b>
3.11.1. <i>Validity</i>	69
3.11.2. <i>Sensitivity to the context</i>	70
3.11.3. <i>Commitment and rigour</i>	70
3.11.4. <i>Coherence and transparency</i>	71
3.11.5. <i>Impact and importance</i>	71
3.11.6. <i>Criteria specific to IPA</i>	72
3.11.7. <i>Generalisability</i>	72
<b>3.12. Reflexivity</b>	<b>73</b>
3.12.1. <i>Methodological reflexivity</i>	73
3.12.2. <i>Personal reflexivity</i>	74
<b>4. Chapter Three: Analysis</b>	<b>77</b>

<b>4.1. Master Theme I: Sense of Control</b>	<b>78</b>
4.1.1. <i>The “constant” worry</i>	78
4.1.2. <i>Fear of failure</i>	81
4.1.3. <i>Controlled awareness</i>	85
4.1.4. <i>Letting go</i>	87
<b>4.2. Master Theme II: Me and the World</b>	<b>90</b>
4.2.1. <i>Romantic relationships</i>	90
4.2.2. <i>Parent-son relationship</i>	95
4.2.3. <i>Sense of shame of loneliness</i>	99
<b>4.3. Master Theme III: Connecting</b>	<b>102</b>
4.3.1. <i>Changing awareness</i>	102
4.3.2. <i>Coming clean</i>	106
4.3.3. <i>Reflections on motivation and recovery</i>	111
<b>5. Chapter Four: Discussion</b>	<b>117</b>
<b>5.1. Sense of Control</b>	<b>117</b>
5.1.1. <i>The “constant” worry</i>	117
5.1.2. <i>Fear of failure</i>	119
5.1.3. <i>Controlled awareness</i>	121
5.1.4. <i>Letting go</i>	123
<b>5.2. Me and the World</b>	<b>124</b>
5.2.1. <i>Romantic relationships</i>	124
5.2.2. <i>Parent-son relationship</i>	127
5.2.3. <i>Sense of shame and loneliness</i>	131
<b>5.3. Connecting</b>	<b>133</b>
5.3.1. <i>Changing awareness</i>	133
5.3.2. <i>Coming clean</i>	134
5.3.3. <i>Reflections on motivation and recovery</i>	136
<b>5.4. Reflections on the Use of IPA and on the Research Design</b>	<b>138</b>
<b>5.5. Personal Reflections</b>	<b>139</b>
<b>5.6. Clinical Implications for Counselling Psychology</b>	<b>141</b>
5.6.1. <i>Sense of control</i>	141
5.6.2. <i>Me and the world</i>	142
5.6.3. <i>Connecting</i>	144
<b>5.7. Avenues for Future Research</b>	<b>147</b>
<b>5.8. Concluding Comments</b>	<b>150</b>
<b>6. References</b>	<b>152</b>
<b>7. Appendices</b>	<b>188</b>

7.1. Anorexia Nervosa Diagnostic Criteria (DSM 5)	188
7.2. Recruitment Advertisement	189
7.3. Ethics Form Approval	190
7.4. Approval of Amendments to Ethics Form	191
7.5. Participant Information Sheet	195
7.6. Consent Form	200
7.7. Debrief	202
7.8. Interview Schedule	204
7.9. Sample of Transcript and Layout	206
7.10. Sample of Analysis: Note-taking and Colour Coding	207
7.11. Sample of Analysis: Theme Clustering	208
7.12. Sample of Table of Themes	209
7.13. Table of Theme Recurrences	210

## **Section B: Combined Client Study and Process Report**

The Role of Awareness in Bringing About Change and  
Nurturing Motivation: Case of Sam

<b>8. Introduction: Demographics, Context and Therapeutic Approach, Rationale for Case Study</b>	<b>223</b>
8.1. <i>Demographics</i>	223
8.2. <i>Context for therapy and therapeutic approach</i>	223
8.3. <i>Rationale for case presentation</i>	224
<b>9. Client Study</b>	<b>225</b>
9.1. <i>Referral</i>	225
9.2. <i>Assessment phase</i>	226
9.3. <i>Formulation</i>	227
9.4. <i>Therapeutic plan</i>	229
<b>10. Intervention</b>	<b>230</b>
<b>11. Outcome and Ending</b>	<b>231</b>
<b>12. Overview of the Process Report</b>	<b>232</b>
<b>13. Transcript and Commentary</b>	<b>233</b>
<b>14. Session Ending and Evaluation</b>	<b>248</b>
<b>15. Reflective Discussion</b>	<b>248</b>
15.1. <i>Challenges</i>	249

15.2. Themes	249
15.3. Dilemmas	250
<b>16. References</b>	<b>252</b>
<b>17. Appendices</b>	<b>255</b>
17.1. Consent to Record Sessions and Use for Academic Purposes	255
17.2. Diagnostic Criteria of Borderline Personality Disorder according to the DSM-5 (APA, 2013)	256
17.3. Schemas and Maladaptive Coping Modes Emerging from the Measures and Formulation	257
17.4. Sam's Mode Map	259
17.5. Imagery Assessments	261

### **Section C: Publishable Paper**

An Exploration of Men's Experiences of Motivation to Change in Relation to their Journey with Anorexia Nervosa

<b>18. Abstract</b>	<b>263</b>
<b>19. Background and Introduction</b>	<b>263</b>
<b>20. Methodology</b>	<b>265</b>
<b>21. Findings</b>	<b>268</b>
<b>22. Discussion</b>	<b>278</b>
22.1. Clinical Implications for Counselling Psychology	278
22.2. Limitations of research and suggestions for future studies	280
<b>23. Concluding comments</b>	<b>281</b>
<b>24. References</b>	<b>283</b>
<b>25. Appendix</b>	<b>289</b>
25.1. Counselling Psychology Review Guidelines	289

## **I. List of Tables, Figures, and Abbreviations**

### **List of Tables**

*Table 1.: Participants' Demographical Details and other Information*

### **List of Figures**

*Figure 1.: Outline of Outline of the Master Themes and Sub-themes*

### **List of Abbreviations**

AN	-	Anorexia Nervosa
BN	-	Bulimia Nervosa
BED	-	Binge Eating Disorder
CP	-	Counselling psychology or Counselling psychologist
ED	-	Eating Disorder
FDA	-	Focouldian Discourse Analysis
Ff	-	Fear of failure
HAM	-	Healthy Adult Mode
MBT	-	Mentalization Based Treatment
MH	-	Mental health
MoC	-	Motivation to change
NA	-	Narrative Analysis
NT	-	Narrative Therapy
PD	-	Personality Disorder
ST	-	Schema Therapy
SDT	-	Self-Determination Theory
TTM	-	Transtheoretical Model of Change

**THE FOLLOWING PARTs OF THIS THESIS HAVE BEEN  
REDACTED:**

Section B. Combined Client Study and Process Report.  
Section C. Publishable Paper.



## **II. Acknowledgments**

I would firstly like to thank the men who took part in this study, this research is dedicated to you. Your generosity has been invaluable and I hope that our work together will contribute to raising awareness around men's struggles with mental health, particularly, with eating disorders.

My gratefulness goes to Dr Erin Reid whose support has been invaluable through the entire doctoral journey. You are a great inspiration for me. I would like to acknowledge the guidance and encouragement of my research supervisor Dr Susan Strauss. Thank you for showing confidence in my work. I feel lucky to have been your supervisee.

Thank you to all my wonderful friends for their support and patience. Particularly Raquel for your unrelenting encouragement and love. Richard for walking the way with me and Erin for your warmth and availability.

Lastly, my deepest gratitude to my family. Your love, presence, understanding, reassurance and kindness has been vital.

### **III. Declaration of Powers**

I grant powers of discretion to City, University of London to allow this Doctoral thesis to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

#### **IV. Preface**

The doctoral portfolio that follows is written in the UK's current context of an increased prevalence of mental health (MH) issues being reported (Mental Health Foundation, 2018) and the impact of austerity on the NHS service provision. These changes are presenting counselling psychologists (CPs) with an opportunity to reflect on their role and how they position themselves within society. Whilst flexibility, creativity and tailoring psychological therapy interventions to clients' unique needs, remain key to our work, we also need to re-examine the ways that CPs intervene to meet the evolving needs of the service users we connect with. Within this preface, I identify a common thread, 'connection' which links each of the components within my doctoral portfolio; the thesis, the combined client study and process report, and the publishable article.

Throughout this preface, the 'research' or 'research study' refers to both the doctoral research paper (thesis) and the publishable paper, as they are grounded in the same project.

'Connection' emerged as an important theme in the experiences of both the participants' of the research study and Sam the client in the combined client study and process report. Firstly, they all longed for shared experience and connection to other people who may have endured comparable difficulties, perhaps to normalise their experiences. Secondly, 'connection' was conceptualised as a way of coming into contact with one's own experience through the acknowledgement and acceptance of one's own vulnerabilities and subjective reality. Research shows that acceptance is one of the underlying phenomena determining change and recovery (Espel, Goldstein, Manasse, & Juarascio, 2016; Kitson, 2012).

##### *Research*

The research, which resulted in the thesis and publishable paper, centres on exploring men's experience of motivation to change (MoC) in relation to their journeys with anorexia nervosa (AN). In the research study, all of the participants cited the opportunity to offer a sense of commonality to other men enduring similar experiences as their reason for participation; they themselves recalled desiring connection with others within their own journeys with AN. Participants also disclosed wanting to share their experience with others at a later stage within their journeys, when on the recovery path. They described hiding away during their AN and re-emerging from isolation marked a new beginning in their recovery, which included an increased awareness and acceptance of their eating disorder

(ED). Two of the men described how listening to former sufferers' lived experiences of AN had contributed to their MoC and to being increasingly open about their experience with others.

It was fascinating to note that some of the participants had found alternative ways of giving voice to their experiences and bypassed MH services through activities such as acting, writing plays, blogging, and journalism, these men created spaces through which others could come together and share their stories. They explained that their actions sustained their MoC and their paths towards recovery and that they themselves were empowered helpers through supporting and offering encouragement to others: "it wasn't just connecting, I felt good about it" (Daniel:129). As Jetten (2018) affirmed, "By building a shared identity, the negatives become positive" (p. 35).

#### *Combined client study and process report*

In the combined client study and process report we meet Sam who had not been allowed to express his emotions and preferences as a child. He experienced exclusion, marginalisation and feeling unwanted within his family and social environment, from a very young age. This was carried over into his adult life in which he felt he never belonged or fit-in, leading him to self-isolate. Sam's presenting problems were formulated by a personality disorder service as borderline personality disorder: characterised by difficulties in regulating his emotions, and a sense of feeling inferior to others which led him to struggle interpersonally. Sam's therapy goal was to better understand his emotions and to improve the quality of his rapport with others.

The stigma of a MH diagnosis compounded Sam's sense of being different and non-belonging. During our sessions, he was curious about the other clients that I was seeing and their presentations. I wondered whether he was seeking connection. He wanted to know more about others and find some common ground with them. At the same time Sam was afraid to be disappointed once again by people and thus felt hindered socially by his fear of being shamed and stigmatised.

My collaborative therapeutic work with Sam involved him gradually connecting to his vulnerabilities and to his challenging experiences. Although painful and extremely challenging, the acknowledgement and acceptance of his childhood and adult experiences were key to him increasing his curiosity about himself. Additionally, Sam's understanding of his cognitive-behavioural patterns, supported him in prioritising his own needs and in spurring his MoC which helped him work towards his goals.

## *Gender and Mental Health*

Gender norms are instilled in children from a very early age (Penn, 2005). Children receive gender normative messages from the systems around them, including families, schools, and the media, and these are consistently reinforced throughout our day to day interactions.

In western societies, a history of gender inequality exists with men holding social power and viewed as the 'dominant' gender. Men are seen as the providers, care takers, and these expectations affect their relationships with women and other men (Courtenay, 2000). Hegemonic masculinity theories explain how men are taught to uphold strength, power, independence and assertiveness (Courtenay, 2000). These messages may include boys believing that they need to be robust and vigorous, to handle situations and to not express their emotions. On the other hand, girls learn that they can be expressive, weak and in need of protection (Costa, Terracciano, & McCrae, 2001). Besides this binary categorisation being restrictive in terms of considering the wide gender spectrum, men being the 'dominant' gender might not always be the case.

Within the context of MH, the gender roles seem to be reversed: Men do not seem to be the 'protagonists'. Here, males appear as a minority, often a marginalised or discriminated group, perhaps because feeling vulnerable and asking for help challenge the social construction of masculinity (Emslie, Ridge, Ziebland, & Hunt, 2006). This situation gives life to a cycle: men find it difficult to seek help, perhaps due to their non-recognition of having a MH issue or the result of hegemonic masculine values of independence. This leads men to suppress or conceal emotion and vulnerability (Ellis et al., 2013), to fear of being stigmatised or to believe that the health system does not have the tools to help them. Health services and wider society struggle to acknowledge, accept and adequately responding to men's MH needs. And as a result this population does not seek help (Räisänen & Hunt, 2014; Strother, Lemberg, Stanford, & Tuberville, 2012). As men who experience MH issues are often not inclined to expose themselves, they inadvertently reinforce the social construction and stereotype of masculinity, which society does not have the opportunity to challenge. As such these stereotypes continue to perpetuate gender inequalities.

## *Broadening the Remit of Counselling Psychologists*

As a researcher and clinician, I bore witness to each of these men's need for 'connection' in their struggle with their MH difficulties. My attention was drawn to the value and power that

having shared experiences and establishing a 'connection' with others, had for these men. Searching for and finding other people with similar experiences, supported the men in acknowledging their difficulties and in being honest with themselves. Thus, this 'connection' impacted on their motivation to tackle their own problems.

As noted above, each of these men were "experts by experience" (Noorani, 2013). Some found novel ways to bypass MH services, and connect with others by giving voice to their experiences. The men were raising awareness of EDs and contributing to combating existing socially constructed barriers of masculinity. Research shows that people who belong to groups and self-identify, regardless of whether the community is deprived or disadvantaged, score higher in terms of well-being than those who lack this sense of belonging (Jetten, 2018). This suggests that sharing an experience can help when an individual is confronted by the challenges of coping alone. This model is seen in action with the Men Get Eating Disorders Too (MGEDT) charity successfully offering support groups for men with EDs (MGEDT, 2017).

Listening to Sam and the research study participants voicing the essential need for connection, and appreciating that this need had not been met by health professionals, naturally drove me to ask myself questions:

Whilst some individuals may find ways to work around the NHS not meeting their needs, by creating novel initiatives, what happens to those individuals who do not have this agency?

How can we support and empower those who are not entering formal MH services?

How can CPs and MH services promote the successful initiatives which have been started by other "experts by experience" (Noorani, 2013)?

Is it right for CPs to wait for GPs' or self-referrals to come through to their specialist services? Is it equitable for CPs to sit in NHS offices expecting sufferers, families, schools and professionals to be well-versed in MH, hence capable of identifying disorders?

CPs can hold leadership role in advancing a more "engaged and activist course for professional psychology" (Toporek, Gerstein, Fouad, & Israel, 2006, p. ix). Perhaps sometimes working 'behind walls' in NHS offices is not the way to combat barriers which impede an array of minorities in accessing MH support. Furthermore, perhaps NHS services using technical jargon does not help marginalised individuals to feel they can be involved in their path towards recovery. These environmental conditions do not encourage access to care and treatment could potentially exclude the very service users they intend to attract. Besides Society's beliefs around men, masculinity and MH acting as barriers to these men addressing their issues and seeking help, CPs too may be contributing to maintaining these

phenomena. "Outcome research in randomized trials focuses on whether change has occurred, whereas for CPs the more interesting question relates to *how* change occurs." (Strauss and Bury, 2006, p. 114). As a result of our training, we are in a privileged position: we can observe and identify changing trends and needs and we have the tools to act on change.

Given the current financial climate within the NHS resulting in cuts limited human, time and financial resources, research findings and their implementation in our practice can give rise to tensions. Nevertheless, working and negotiating the complicated tensions between research and practice are an opportunity to reconsider our role creatively and flexibly in line with our ethos (BPS, 2009). Perhaps it is time for CPs to ask ourselves, what is at stake and what is possible in our profession?

Our traditional ways may not remain effective as times change; perhaps it is time to challenge the ways we help people. It seems key to become more present and active, physically and with our evidence-based knowledge. Without being involved completely and amalgamating in society, we risk in colluding with the current status quo which risks maintaining inequity. As CPs our job is to provide psychologically informed treatment but to also offer consultations, engage in campaigns and train service users and other professionals. We need to flexibly and creatively adapt in light of this evolving society.

### *Personal reflections*

The theme 'connection' hugely impacted on my understanding of the CP profession. CP is founded on building solid collaborative relations between therapists and clients (Norcross & Wampold, 2011). Based on authenticity and mutual trust these key components have the potential to bring about change. However, through these pieces of work, I came to understand that although building therapeutic alliances with clients within the therapy room would always lay at the heart of my work as a therapist, the concept of 'connection' could have great potential and a wider scope. How will I reach those people who fall through the net of a system which is stifled by cuts? How will I support those who do not seek help because of their fear of being stigmatised? How can I help those whose difficulties are not recognised by them or those around them?

These questions made me reconsider my role as a future CP. My reflections impacted on the criteria I had when recently seeking for a job within the NHS. As CPs we have the skills and duty to devise and propose programmes which respond to societies' (including clients')

changing needs. I wanted to find a position which would challenge my creativity in designing care around clients' needs and goals, not merely based on psychological therapy, but also through providing consultations, building working alliances with other health professionals, local authorities and charitable organisations, to coordinate care for service users. Moreover, I wanted to secure a job which would foster service users' involvement in for instance, training other health workers or offering support services to carers, families, or sufferers. I realise now that these preferences engendered my desire to, as a CP, be involved in developing strategies which could connect people to ensure they receive the best care.

With this doctoral portfolio I seek to give a voice to men in their struggle with MH in general, not just in the context of AN or EDs. I intend to contribute to raising awareness around men's lived experiences. Through increasing and improving the quality of connection, I hope to stimulate a conversation aimed towards equal treatment opportunities, with positive outcomes for men in terms of help seeking, receiving support, and in accessing professional care. This portfolio hopes to contribute to 'levelling the playing field' in terms of gender and equal opportunities: all people, regardless of sexuality or gender have the right in: feel supported by those around them, feel self-assured in seeking help when ready, be diagnosed if ill, and ultimately have equal access to treatment. It was a privilege to hear each man tell their story. it is my hope that each of the recommendations which emerge from the study help to level this playing field; they stem directly from the experiences of the men who each, with their hope of finding connection, became involved in the portfolio that follows.



## References

- British Psychological Society Code of Ethics and Conduct (2018). [online] Retrieved from:  
<https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%282018%29.pdf>  
[Accessed on 28 April 2018].
- Bury, D. & Strauss, S. M. (2006). The scientist-practitioner in a counselling psychology setting.  
In, D. A. Lane & S. Corrie (Eds.), *The Modern Scientist-Practitioner: A Guide to Practice in Psychology*. (pp.112-126). London: Routledge.
- Costa Jr, P. T., Terracciano, A., & McCrae, R. R. (2001). Gender differences in personality traits across cultures: robust and surprising findings. *Journal of personality and social psychology*, 81(2), 322.
- Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science and Medicine*, 50(10), 1385-1401.
- Ellis, L. A., Collin, P., Hurley, P. J., Davenport, T. A., Burns, J. M., & Hickie, I. B. (2013). Young men's attitudes and behaviour in relation to mental health and technology: implications for the development of online mental health services. *BMC psychiatry*, 13(1), 119.
- Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity? *Social Science & Medicine*, 62(9), 2246-2257.
- Espel, H. M., Goldstein, S. P., Manasse, S. M., & Juarascio, A. S. (2016). Experiential acceptance, motivation for recovery, and treatment outcome in eating disorders. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, 21(2), 205-210.
- Jetten, J. (2018). Reversing the social curse. *The Psychologist*, 5, 32-35.

Kitson, C. (2012). Motivation to change. In, J.R.E. Fox & K.P. Goss (Eds.) *Eating and its Disorders* (pp.75-101). Chichester: Wiley and Sons.

Men Get Eating Disorders Too (2017). [online] Retrieved from:  
<https://mengetedstoo.co.uk/services/sedspeer2peer>  
[Accessed on 30 April 2018].

Mental Health Foundation (2018). [online] Retrieved from:  
<https://www.mentalhealth.org.uk/statistics/mental-health-statistics-uk-and-worldwide>  
[Accessed on 29 April 2018].

Noorani, T. (2013). Service user involvement, authority and the 'expert-by-experience' in mental health. *Journal of Political Power*, 6(1), 49-68.

Norcross, J. C., & Wampold, B. E. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy*, 48(1), 98.

Penn, H. (2005). Understanding early childhood. In, *Unequal Childhoods* (pp.57-76). London:Routledge.

Räisänen, U., & Hunt, K. (2014). The role of gendered constructions of eating disorders in delayed help-seeking in men: a qualitative interview study. *BMJ*, 4(4).  
doi: 10.1136/bmjopen-2013-004342.

Strother, E., Lemberg, R., Stanford, S.C., & Tuberville, D. (2012). Eating disorders in men: underdiagnosed, undertreated, misunderstood. *Eating Disorders*, 20(5), 346-355.

Toporek, R., Gerstein, L.H., Fouad, N.A., Roysircar, G., & Israel, T. (2006). *Handbook for social justice in counseling psychology: Leadership, vision, and action*. London:Sage.

## **Section A: Doctoral Research Paper**

An Exploration of Men's Experiences of Motivation to Change in Relation to their  
Journey with Anorexia Nervosa.

## 1. Abstract

The incidence of eating disorders (EDs) is increasing. According to the NHS digital data male diagnoses of EDs have also risen significantly and hospital admissions of adult men with EDs increased by 70 per cent between 2010 and 2016. It is reported that men often refrain from seeking help as showing vulnerability is deemed incompatible with the westernised social construction of masculinity and EDs in men frequently go unrecognised. Hence, figures may not reflect true incidence. Studies show that motivation to change (MoC) in patients with Anorexia Nervosa (AN) is key for effective treatment response and recovery. Autonomy in patients' motivation can predict long-term outcomes; it provides an internal locus of control enabling individuals to be an active agents within their struggle. Studies on MoC in EDs, like ED research more generally have mainly yielded quantitative data and focused on women.

This study focuses on the experiences of men's MoC in relation to their journeys with AN. It is anticipated that focusing on this under-explored topic will contribute to better understanding of men's experiences of AN. This also may help lift the stigma attached to males who have an experience of ED or more generally of mental health (MH) issues.

Eight English-speaking men were recruited using purposive sampling to participate in this research. Interpretative Phenomenological Analysis (IPA) was employed to conduct this study and involved semi-structured interviews as a means of collecting data. Interviews were transcribed and analysed according to the IPA guidelines yielding three master themes. Themes were interpreted using the existing literature on EDs and MoC. Use of reflexivity emerges throughout the study.

The master themes generated from the data analysis were: 'sense of control', 'me and the world', and 'connecting'. These master themes comprised of ten subthemes. The research findings invite professionals to shift existing thinking in the context of men's MoC and agency regarding engaging in behaviours to the detriment or to the benefit of their health throughout the progression of their illness. The results of this study are discussed in relation to existing literature pertaining to EDs and MoC, in particular of men's experiences of AN. The applicability of these findings for counselling psychologists' (CPs) practice is discussed. A critical consideration of the findings will then lead to recommendations for future research.

## **2. Chapter One: Introduction**

### **2.1. Overview**

This study seeks to explore men's experiences of MoC in relation to their journeys with anorexia nervosa.

EDs are present across ages, ethnicities, socioeconomic groups, and gender. The higher incidence of EDs in females is likely to have directed interest and need to conduct research with women (Sweeting et al., 2015). This gender imbalance, seems to have encouraged the stereotype that EDs are a female issue; however, this is not the case (Darcy, 2011; MacLean et al., 2015). This misconception appears to have impacted on other sufferers. For instance, research reported that men may feel ashamed of their EDs and are reluctant to seek help as their illness and sense of vulnerability contrasts with social constructions of gender (Ali et al., 2016; Räisänen & Hunt, 2014). Despite the National Institute for Health and Care Excellence (NICE, 2017) recommendations on equal access to treatment for males and females, studies have shown that the belief that EDs are gender-specific illnesses, can influence professionals leading to misdiagnoses or underdiagnoses of EDs in men (Strother, Lemberg, Stanford, & Tuberville, 2012). Moreover, most ED services have been developed around women's needs, and are therefore often unable to accept men or may place them on longer waiting lists (Marsh, 2017). Delaying care can increase discomfort and dropout rates when receiving psychological treatment (Carter et al., 2012). The general public, including family and friends of sufferers, can also be inherently influenced by this stereotype, resulting in non-identification of the struggle of the male sufferer, attitudes of non-acceptance due to the condition, and therefore missed opportunities to offer support (Langley, 2006).

Numerous studies declared that MoC is key for commitment to treatment, effective recovery, and relapse prevention in EDs (Casasnovas et al., 2007; Pauli, Aebi, Winkler Metzke, & Steinhausen, 2017; Thaler et al., 2016). Yet, research on MoC in EDs seems to have predominantly been conducted with women and has centred on EDs in general (Clausen, Lubeck, & Jones, 2013; Nordbø et al., 2008; Vansteenkiste, Soenens, & Vandereycken, 2005).

Studies featuring men in relation to their experience of EDs seem to be significantly less compared to those carried out with women (Cohn & Lemberg, 2013). Casasnovas and

colleagues (2007) recommended that studies on motivation in EDs should involve homogenous samples in terms of diagnosis and that AN patients are the least likely to be motivated for change. From a CP point of view, it appears that there is a need for further research with men who experienced AN. Understanding men's experiences and treatment needs for AN is necessary to raise awareness of the phenomenon, to support sufferers, their families and carers and to help the work of professionals, to offer care and treatment of excellence. For these reasons this study sets out to focus on the experience of men's MoC in relation to their journey with AN.

This chapter aims to approach the current study by introducing the reader to the literature on EDs and their connection with men, and to explore the existent literature on MoC in relation to EDs. Whilst leading towards the rationale for this research, this chapter's purpose is to serve as a guide in to the current study.

This chapter, will first provide an overview of EDs, including recent statistical findings, to note the importance of up to date research in improving our understanding of AN. It will then outline a selection of the topics which have been explored in research with EDs. An overview of the findings regarding EDs in men will follow, connecting a brief history with current media attention. Recent amendments of the diagnostic criteria of AN in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (APA, 2013) will be discussed. Subsequently, it will address gender conceptualisation in relation to men and MH including men and EDs. This chapter will also present treatment of EDs and recent findings regarding treatment experiences for men. Then, the relevance of MoC in EDs, thus in AN will be introduced. This part will also address its importance for the CP field. A critical literature review concerning MoC in EDs will follow. The last section will offer a summary and lead into the current study.

Due to the limited research focusing only on AN I will aim to provide information on EDs in general, where information on AN is not available, in order to cement the topic within a broader context.

#### *Focus on motivation to change in this thesis*

This thesis will focus on men's experiences of MoC across the entirety of their journey with AN; from its initial presentation, through the condition's development over time, to the shift towards recovery. Attending the sufferers' MoC from a holistic perspective encourages the

focus on the role of their *agency* across all stages of this illness. As mentioned above the relevance of MoC for AN will be addressed and explained in this chapter (section 2.4.).

## **2.2. An Outline of EDs and Recent Figures**

The UK's ED charity BEAT (2018) estimated that 1.25 million people in the UK have an ED. EDs are very complex to outline and accurately define; they can change over time, and may develop alongside other psychiatric disorders (Striegel-Moore et al., 1999; Swinbourne et al., 2012). DSM 5 (APA, 2013) identifies eight EDs: the most well-known EDs are AN, bulimia nervosa (BN), binge-eating disorder (BED) (APA, 2013). Others are pica, rumination disorder, avoidant/restrictive food intake disorder (ARFID), other specified feeding or eating disorder (OSFED), and unspecified feeding or eating disorder (UFED).

AN is characterised by a low body weight in relation to one's gender, age, and height (APA, 2013). People who suffer from AN tend to fear weight gain and becoming fat (Becker, Thomas, & Pike, 2009), and engage in behaviours that impede this (Mallick, Ray & Mukhopadhyay, 2014). In some cases, individuals may experience a distorted sense of their body shape and appearance (Waldman, Loomes, Mountford, & Tchanturia, 2013). Their perceptions can encourage them to minimise or hide their behavioural and psychological symptoms (Marks, Beaumont, & Birmingham, 2003). Minimisation of symptoms and concealing behaviours may manifest in wanting to be alone and avoiding social situations when eating (Gavin, Rodham, & Poyer, 2008). Other signs of AN are an ongoing daily preoccupation with physical exercise and calorie intake and consumption (APA, 2013; Bruch, 1978). AN sufferers may sometimes lack cognitive flexibility, show diminished ability of central coherence and reduced theory of mind (Bora & Köse, 2016; Lang et al., 2014; Tchanturia et al., 2012). According to the DSM 5, there are two subtypes of AN, restricting type AN (AN-R) and binge-eating/purge type (AN-BP) (APA, 2013) (appendix 7.1. for AN diagnostic criteria).

The next part aims to provide recent findings including statistical figures on EDs (and where possible on AN) in the UK. AN has the highest mortality rate of any mental illness (Arcelus, Mitchell, Wales, & Nielsen, 2011; Beaumont & Touyz, 2003; Chesny, Goodwin & Fazel, 2014; Kask et al., 2017). The research review completed by Keel and Brown (2010) revealed crude mortality rates<sup>1</sup> of 0-8 per cent with a cumulative mortality rate<sup>2</sup> of 2.8 per

---

<sup>1</sup> no. of deaths/average population x 100,000

<sup>2</sup> no. of deaths within a set period of time/total population before set period of time

cent for AN. Less than half of the sufferers appear to recover completely from AN and large part develop a severe and enduring form of the disorder (Danielsen et al., 2016; Touyz et al., 2013). According to Steinhausen (2009), 20 per cent of those diagnosed with AN develop chronicity and half of them show comorbidity with a psychiatric disorder.

EDs are dangerous and treatment is crucial. Self-harm leading to suicidal behaviours is prevalent in all EDs including AN, BN, and BED (Kostro, Lerman, & Attia, 2014). Moreover, weight loss, fatigue, depression, amenorrhoea, low testosterone levels, impotency, bradycardia, organ damage, anaemia, osteoporosis, and tooth decay are some of the afflictions that EDs may lead to (Greenberg & Schoens, 2008).

The incidence of EDs is increasing (Micali, Hagberg, Petersen, & Treasure, 2013). Marsh (2016) stated that hospital admissions of adult men with EDs increased by 70 per cent between 2010 and 2016, which is equal to the rate for women's admittance to hospital for EDs. Moreover, according to the NHS digital data from 2015 to 2016, male diagnoses of EDs have almost doubled compared to data from 2010 to 2011 (Marsh, 2016).

Despite the wide variety of available treatments, some sufferers do not seek professional help (Räisänen & Hunt, 2014). Many show resistance to treatment (Abbate-Daga, Amianto, Delsedime, De Bacco, & Fassino, 2013), or have thoughts, feelings, or experience symptoms, that do not match the diagnostic criteria, consequently risking being misdiagnosed (Birgegard, Gross, de Man Lapidoth, & Norring, 2013). BEAT found that 50 per cent of those who seek help from a GP rate their care "poor" or very "poor". Furthermore, 30 per cent of people who sought help in primary care were not referred to a specialised service (Marsh, 2016). Fairburn (2005) contended that adults show significantly lower recovery rates compared to children and young people. He argued that this does not relate to the efficacy of treatment, rather, adults resulted in having established "maintaining mechanisms" (Fairburn, 2005, p. 29) challenging change, whereas younger individuals were found more responsive to treatment.

No universal care, medical treatment, psychological therapeutic approach or support method that suits all sufferers would appear to exist for EDs. Reasons may include, but are not limited to, the frequent comorbidity with other MH issues, the complexity of EDs, severity, family support, life ambitions and willingness to change combined with the individuals' biopsychosocial variables (Bodell & Keel, 2010). Further research in EDs is imperative to informing professionals and offering high quality specialist services to sufferers, and their families and carers.



## **2.3. Literature Review**

### *2.3.1 Research conducted on EDs: a selection of topics*

To give the reader a flavour of the principal areas on which research on EDs has focused this section will outline certain aspects of research on EDs and will describe some of the findings. This snapshot can also serve as a preliminary guide to acknowledge gaps in the literature and to direct the reader towards the research question of the current study.

#### *Assessment and diagnosis*

Research has involved the creation of classification and assessment tools for EDs, these studies are generally based on large samples and nomothetic data (Morgan, Reid, & Lacey, 1999). For example, the SCOFF (Hill, Reid, Morgan, & Lacey, 2010; Luck et al., 2002) is widely used for assessing EDs and recommended by NICE (2017). This measure can be criticised for being low in sensitivity, specificity, and lacking the properties to identify EDs across genders (Solmi, Hatch, Hotopf, Treasure, & Micali, 2015). This implies that the SCOFF, like other psychometric tools, may fail to identify individuals with an ED in diverse multi-ethnic environments such as London. NICE (2017) cautions to use screening tools prudently, by complementing their use with other practices such as parents' and carers' involvement during assessments therefore, taking into consideration behavioural changes which apply to the unique experience of each individual.

It seems that despite the wide range of assessment tools for EDs, there are barriers which may act as impediments for sufferers seeking, and accessing, professional care (Ali et al., 2017; Räisänen & Hunt, 2014; Strother et al., 2012). Ali and colleagues (2016) systematically reviewed past enquiries on barriers for help-seeking or receiving care. They confirmed that feeling stigmatised and shamed, being in denial or failing to comprehend the severity of the illness, one's lack of MoC, absence of encouragement from others to seek help and adverse attitude towards help seeking may hinder the sufferers' from asking for help. Bora and Köse's (2016) meta-analysis examined theory of mind in people with AN and BN showing that people with AN have significant deficits of theory of mind. This might link to the sufferers' difficulty to acknowledge the severity of their illness, thus to seeking help. Furthermore, EDs are often identified with extremely thin young females, and research indicated that primary care fails to identify and diagnose 70 per cent of ED presentations in the UK (Currin et al., 2007).

As many cases remain unidentified or unrecognised, it seems that there is a need to expand the public's and professionals' knowledge of EDs' presentations. Society's greater awareness of the wide spectrum of ED presentations may also facilitate sufferers themselves in coming forward to ask for help (Soban, 2006; Waller, Micali, & James, 2014).

### *Risk*

Research also uncovered possible risk factors of these illnesses (such as, environment, media exposure, attachment styles, sexuality and socioeconomic status), their onset, and their development, including its symptoms (Mabe, Forney, & Keel, 2014; Calado et al., 2010).

Numerous studies have looked at the risk associated with EDs, such as mortality rates, and their comorbidities, for example, depression, obsessive-compulsive disorder, and substance abuse (Arcelus et al., 2011; Froreich, Vartanian, Grisham, & Touyz, 2016; Striegel Weissman & Bulik, 2007).

### *Relationships*

Studies have sought to investigate sufferers relationship interactions in the world across their lifespan and within different settings, for instance, parent-child, romantic relationships (Dare, Le Grange, Eisler, & Rutherford, 1994; Fischer, Baucom, Kirby, & Bulik, 2015; Garcia, Seidinger, & Turato, 2013; Horesh, Sommerfeld, Wolf, Zubery, & Zalsman, 2015).

Multiple enquiries showed that people with EDs experience relationship difficulties with family members. Literature which has been discredited for its "weak" empirical support (Dare et al., 1994; Le Grange, Lock, Loeb, & Nicholls, 2010) showed that certain interactions within the family and system were a direct and primary cause for onset and maintenance of EDs. Moreover, mothers are often "scapegoated" by doctors, husbands, sufferers (Dally, 1977, p. 470). Minuchin, Rosman, and Baker (1978), although acknowledging that certain familial dynamics were not helpful, began to understand the family system as a means to assist the sufferer and the family; altering certain interactions through therapy may have changed the course of AN for sufferers. Minuchin and colleagues (1978) hence reframed the role of the family in the context of AN introducing the concept of the "psychosomatic family". In the 1970s the Maudsley Hospital in London further shifted the position of the family in the

context of EDs conceptualising it as a resource in therapy rather than a problem or maintaining factor for EDs (Dare & Eisler, 1994).

Families' inclusion in the treatment of AN outpatients is recommended to date (Watson & Bulik, 2013; Treasure, Smith, & Crane, 2016). Family therapy includes partners of ED patients as problems with intimacy and communication often feature in romantic relationships, and certain relational dynamics may contribute to the maintenance of the ED (Arcelus, Yates, & Whitely, 2012). Family involvement improves communication amongst its members promoting sufferers' support (Treasure et al., 2016); furthermore, effectively supporting the sufferers has natural implications on their MoC in embarking on their journey towards recovery (Zaitsoff & Taylor, 2009). Family members caring for people with an ED have shown low quality of life due to persistent sense of anxiety and concern (Treasure, Whitaker, Whitney, & Schmidt, 2005). Improved communication within the family unit further positively impacts its members' self-care and support for each other (Engman-Bredvik, Carballeira Suarez, Levi, & Nilsson, 2015; Treasure et al., 2016).

#### *Socio-cultural norms, sexuality and gender*

Researchers have attempted to analyse the role of cultural norms and ethnical backgrounds in people's experiences of EDs (Katzman, Hermans, van Hoeken, & Hoek, 2004; Makino, Tsuboi, & Dennerstein, 2004).

EDs in men are less frequent than in women (Strother et al., 2012). The lower occurrence in men, might be related to a limited interest in conducting research with men and therefore to scarce evidence around men's experiences (Mitchison & Mond, 2015; Thompson, 2017). Inadequate amount of research and knowledge around men and EDs might be promoting the stereotype whereby EDs are women's only illnesses, and consequently inhibiting men to come forward when experiencing EDs (Marsh, 2017).

Enquiries have considered links between sexual orientation or gender and the incidence, prevalence and experience of these illnesses (Feldman & Meyer, 2007; Robinson, Mountford, & Sperlinger, 2012). Peate (2011), reported that 80 per cent of the men who seek help are heterosexual, other studies' results contradict this finding (Chung & Bravender, 2011). Although professionals and the general public associate EDs in men with homosexuality, research findings seem inconsistent (Cuban, 2013)

#### *Experiences of recovery*

A variety of studies have set out to explore the experiences of recovery including MoC, perception of health care services and treatment (Reid, Williams, & Burr, 2010; Waller, 2011; Clausen et al., 2013). People with EDs are often ambivalent as to whether they want to maintain their ED or recover from it (Williams & Reid, 2012). MoC appears to be key for recovery (Pauli et al., 2017; Wade, Frayne, Edwards, Robertson, & Gilchrist, 2009), and a wealth of literature has focused on its predictive value for treatment drop-out rates and successful recovery (Dovydaityene & Maslauskienė, 2013; Vall & Wade, 2016). Aspects of eating-disordered behaviour are ego-syntonic<sup>3</sup> (Gale, Holliday, Troop, Serpell, & Treasure, 2006; Gregertsen, Mandy, & Serpell, 2017), which seems to shed light on ambivalence towards recovery and change. Studies on MoC in EDs have mainly focused on women, and have yielded quantitative outcomes (p. 29, para. 1). Whilst MoC in EDs appears to be crucial for effective recovery and relapse prevention, further research is needed to recognise the nuances amongst sufferers which may help professionals, family, carers, and society better understand the phenomenon.

### *Trends in research on EDs*

Most of the studies in EDs have sought to produce quantitative data which can be generalisable across cases (Paulson-Karlsson & Nevenon, 2012). Given the current situation whereby insurance companies dictate the service (inpatient or outpatient), therapeutic approach, therapy duration and frequency; Hubble, Duncan and Miller (1999) acknowledged that, it is ever more important to establish empirically validated psychological treatments. In line with the aforementioned trend, whereby it seems favourable to deliver standardised care where possible, enquiries have often looked at common characteristics amongst sufferers. For instance stages of MoC, where individuals are allocated to categories which correspond to certain kinds of treatment strategies (Carter, Byrne, Allen, & Fursland, 2014; Guarda, 2008). However, Carter and colleagues' (2014) study on readiness and MoC showed the importance of rigorously focusing and monitoring each individual's unique response to attain an understanding of the sufferer's needs and hopes to tailor care accordingly.

Quantitative methods in EDs enquiries, have guided the development of my research question for this study. It appears that ED research needs to dedicate more attention to the

---

<sup>3</sup> "Behaviour and wishes are said to be ego syntonic if they are compatible with the subject's ideals and conception of himself" (Rycroft, 1968, p. 41)

idiosyncrasies of the individuals. Developing an understanding of the thoughts underpinning a sufferer's experience might help to avoid falling between the cracks for those who do not fit the diagnostic criteria by the book and those who do not reflect the ED sufferer stereotype.

### *2.3.2. Men and EDs: Brief history and recent media presence*

In 1879, Sir William Gull coined the term “anorexia nervosa” (Pearce, 2006) however two centuries earlier, Sir Richard Morton first reported on anorexia (Silverman, 1988). He identified two cases, a young woman and man, describing AN as a “nervous consumption” condition caused by “sadness and anxious cares” (p. 439). After that, AN had not been linked to males for over a century.

The trend slowly changed in the 1960s, when at a London hospital, Crisp included males in his studies on EDs (Andersen, 2013). Prior to this, issues had been raised by the British Eating Disorder Association (EDA), around identifying the illness in males, their access to services and their specific treatment needs (Copperman, 2000).

Research on AN, however, has continued to be predominantly focused on females and, until its last edition, the DSM-IV TR (APA, 2000) reflected this tendency within its diagnostic criteria by including endocrine requirements for females only, such as amenorrhoea. The International Classification of Disorders (WHO, 1992) do not include specific assessed endocrine requirements for males, but refer to loss of sexual interest and potency. To date, men do not seem to have a stringent “biological indicator” to meet the diagnosis of AN. On the other hand, women sometimes do: the illness had been related to post-partum complications and to amenorrhoea (Andersen, 2013). The NICE guidelines (2017) also do not make specific references to male sufferers.

According to Hudson, Hiripi, Pope and Kessler (2007), males' incidence rate of AN was 25 per cent of the AN population despite it being immediately associated with a females-only illness (Symonds, 2017). It is unsurprising that, given the historical diagnostic standards and the lower incidence within males, professionals as well as the general population have learned to associate this illness with females. These factors may have supported the stereotypical association of AN with women (Stokes, 2013), with ramifications for men's reluctance to report their struggles. Gender biases and social constructions of gender might be responsible for the underdiagnoses of AN in men and their hesitance in help-seeking (Pudge, 2017). These then might be contributing to the misidentification and misdiagnosis of AN in men, amongst sufferers' families, carers, and health professionals, and the lack of

knowledge regarding how to support sufferers; therefore, to the missed opportunities for offering treatment. Sweeting and colleagues (2015) revealed conflicting statistics between web-based UK newspaper articles, which reported a higher male prevalence of EDs, and scientific literature. Figures generated by the newspapers appeared to correspond to data produced by an online “authoritative source” (Sweeting et al., 2015, p. 86). The researchers indicated that a large proportion of men suffering from EDs were not considered clinical cases as they were in the community and undiagnosed. Inaccurate information regarding “male susceptibility to EDs can reinforce inappropriate stereotypes of EDs being confined to adolescent girls” (Sweeting et al., 2015, p. 86) and may continue to feed a vicious cycle where men do not receive the help they require.

However, recent media attention in the UK has been focusing on EDs in males, signifying a radical shift in people’s perceptions. Daily newspapers such as The Times (Stokes, 2013) and The Guardian (Marsh, 2016), and blogs like The Huffington Post (Pudge, 2017) amongst others, have dedicated articles to men’s experiences and *battles* with these disorders. The sources could be seen as offering opportunities to reconsider the legitimacy of gender stereotypes tied to EDs. Furthermore, in July 2017, Nigel Owens, an international rugby referee featured in BBC’s Panorama’s programme on “Men, Boys and Eating Disorders” (Owens, 2017). He disclosed his personal struggle with BN describing the emotions and difficulties he faced in everyday life. Within the same programme, Owens interviewed other men who had experienced EDs. Features in the media can have a significant impact on public perceptions around ED sufferers being both male and female.

Whilst research on male experiences of EDs appears to be limited, media attention seems to unequivocally indicate the desperate need for increased consideration of men and their EDs. More attention to prevalence in men might help lift the stigma attached to the occurrence. Up-to-date research is needed to continue to raise awareness, expand knowledge and deepen understanding, thus improving prevention, care, clinical practice and service provision.

### *2.3.3. An overview on gender conceptualisation in relation to men and EDs*

#### *Gender and mental health*

According to Courtenay (2000) men’s health behaviours and beliefs are related to them suffering more chronic health conditions, having a higher mortality rate than women for fifteen causes of death and for, on average, dying seven years earlier than women.

Ethnicity, social status, life style, activities, and access to care are some of the factors impacting on people's health and life expectancy (NICE, 2012). However, these do not account for gender differences. Many studies have demonstrated that men are more inclined towards risk-taking behaviours such as drinking alcohol, not seeking help, fighting (De Visser & McDonnell, 2012; Harris, Jenkins & Glaser, 2006; Ng et al., 2014). Women, on the other hand engage in more positive health behaviours (Mahalik, Burns, & Syzdek, 2007). Attempting to explain this phenomenon, theories around men's and women's attitudes and beliefs have, more recently, taken a social constructivist perspective (Courtenay, 2000). From this perspective, men, like women, have beliefs and engage in behaviours (including health-related views and behaviours), through which they express their masculinity or femininity (Lyons, 2009). This view is in contrast with older notions such as the sex (or gender) role theories of socialisation (Goldberg, 1976; Nathanson, 1977; Verbrugge, 1985). These theories have been criticised by Connell and Messerschmidt (2005), Kimmel (1986), and Pleck (1987), amongst others, for not acknowledging power, for understanding gender as two mutually exclusive rigid categories and for viewing females' and males' personalities as one-dimensional. Feminist theory (Butler, 1987) and more recent studies on men have conceptualised gender as a "dynamic social structure" (Courtenay, 2000, p.1387) and the result of social transactions in everyday life "practices" and "performance" (Lyons, 2009). Society uses stereotypes to construct gender, defining what is typically masculine and feminine to each context or environment across cultures, and repetition of "daily activities" reinforce them (Paechter, 2003). Research indicated that men use health related behaviours to express their male identity which is closely linked to power, control and strength (Courtenay, 2000; Emslie, Ridge, Ziebland, & Hunt, 2006). Masculine ideals appear to be perceived as incompatible with help seeking (Räisänen & Hunt, 2014). Thus, for example, men may not ask for help because "hegemonic forms of masculinity" feature "emotional control" (Emslie et al., 2006, p.1) or non-manifestation of weaknesses. Whilst MH issues may be associated with vulnerability or helplessness, men may feel uncomfortable in seeking support and choose to remain quiet.

### *Gender and EDs*

This section intends to provide a brief overview of the literature concerning gender in relation to MH and to EDs. ED literature predominantly attends to women's experiences. A limited amount of studies focused on men's understandings of EDs (Pettersen, Wallin, & Björk, 2016). Latest figures revealed that the "number of men admitted to hospital with EDs grew at the same rate as among women between 2010 and 2016" (Marsh, 2017, para. 1). It

seems relevant to introduce the literature regarding males with EDs, to offer the reader a taste of the research findings on EDs with males.

As previously mentioned, EDs are often automatically associated with a women's-only illness, which may lead male sufferers to feel not "masculine enough" (Drummond, 2002; Johnson, 2017, para. 1). However, ED services reported increasing numbers of men being diagnosed (BEAT, 2017). Moreover, studies suggested that the mortality rate for men with EDs is higher than for females (Raevuori, Keski-Rahkonen, & Hoek, 2014).

Research findings have shown that the clinical features of EDs may manifest in similar ways across genders (Hay, Loukas, Philpott, & 2005). For instance, ambivalence towards the ED, and perfectionistic behaviours and psychological distress seem to characterise men and women in similar ways (Bardone-Cone et al., 2010; Nordin-Bates, Walker, & Redding, 2011; Serpell, Treasure, Teasdale, & Sullivan, 1999; Striegel, Bedrosian, Wang, & Schwartz, 2012). Moreover, men and women with EDs frequently manifest similar comorbidities such as anxiety, depression, excessive exercise, and substance abuse (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004; Weltzin, 2014). Furthermore, there appears to be an agreement that treatment is similar between males and females (Fox & Goss, 2012). The DSM 5 confirms that the emotional, physical and behavioural phenomena of AN are similar between men and women (APA, 2013).

Nevertheless, differences across genders seem unequivocal. Despite studies on males with EDs being limited, findings indicate that gender differences may relate to the social construction of masculinity (Carlat, Camargo, & Herzog, 1997; Strother et al., 2012): according to research, both men and women with EDs may feel stigmatised (Griffiths, Mond, Murray, & Touyz, 2014). However, Strother et al. (2012) and Jones and Morgan (2010) reported that males might struggle with a 'double-stigma'. Males often find themselves burdened further by the anxiety of having an illness which is associated with females (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Holliday, Wall, Treasure, & Weinman, 2004). Moreover, research indicated that men are reluctant in seeking help for treatment related to MH issues, including EDs (Ali et al., 2016; Button, Aldridge, & Palmer, 2008). Furthermore, men, like women display anxiety regarding their body shape and appearance (Striegel-Moore et al., 2009). However, in contrast to women, they are preoccupied with building a muscular figure rather than trying to achieve extreme slenderness, and are usually more focused on their upper body (Griffiths, Murray, & Touyz, 2013).

#### *Risk factors in men with EDs*



Some of the risk factors for engaging with an ED appear to be specific to males. For instance, EDs males seem to have a later age onset (Guegen et al., 2012; Mitchison & Mond, 2015; Zerwas et al., 2015). Studies have shown that males may manifest higher occurrence of psychiatric comorbidities (Carlat et al., 1997; Striegel-Moore, Garvin, Dohm, & Rosenbeck, 1999). Bunnell's (2010) investigation corroborated previous research, whereby men who suffer from an ED often have had a history of obesity, being bullied, teased, and shamed during their school years (Guegen et al., 2012; Carlat et al., 1997). Kindlon and Thompson (1999) described males' upbringing as a "culture of cruelty" (p. 72) where competition and conflict are part of socialising, and vulnerability is not accepted. In this "culture", muscles are seen as a synonym of strength, independence and masculinity. In line with this finding, Olivardia, Pope, Borowiecki, and Cohane (2004) have found that men's motivation to develop a muscular figure and body dissatisfaction are linked to depression, low self-esteem, and ED symptoms.

Various studies investigated on men's sexuality in relation to their experience of EDs (Strong, Williamson, Netemeyer, & Geer, 2001; Tiggeman, Martins, & Kirkbride, 2007). As mentioned above, to date results seem inconsistent as to whether homosexuality can be considered a risk factor for developing an ED (Chung & Bravender, 2011; Peate, 2011). Feldman & Meyer (2007) reported that 5 per cent of males who are diagnosed with an ED are heterosexual whilst 15 per cent are homosexual. Nonetheless, these findings can be critiqued for not distinguishing between bisexual and homosexual participants, thus creating a larger participant sample. Strong et al. (2001) reported that homosexual men are more inclined to come forward and ask for help than heterosexual men. Moreover, gay men who are diagnosed with an ED may initially seek help due to another MH issue as they self-report MH is at the top of their health concerns and the rates of depression and suicidality are higher in this population (Lee, Oliffe, Kelly & Ferlatte, 2017). This may explain the higher percentage of men being diagnosed with these illnesses.

It seems imperative to enquire further into men's experiences of EDs to improve our understanding and to provide excellent care and treatment.

#### *2.3.4. Treatment*

##### *Treatment guidelines for EDs*

This section will provide an overview of the existing treatment guidelines, including current psychological approaches, used in the care for EDs, and where available for AN.

NICE and the Royal College of Psychiatry (RCPsych) have developed treatment guidelines and protocols for working with people with EDs. NICE (2017) provides guidance for inpatient and outpatient services. It recommends the involvement of multidisciplinary teams (MDTs) coordinated with other services. It suggests offering talking therapies (group and individual) to patients, whilst closely monitoring weight, other physical or MH issues and risk. NICE (2017) encourages involving families and carers where possible. The RCPsych's Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) (2014) work group produced a report aiming at advising professionals in primary and secondary settings on assessments, logistical, medical, and nutritional management of patients, and on use of MH guidelines and legislation. Like most of the research in EDs, guidelines and protocols are based on research conducted mostly with women. NICE and the RCPsych offer advice for working with different age groups but do not specify gender needs, which may make working with men challenging for professionals.

### *Psychological approaches for treating AN*

This section describes psychological treatment methods employed with people suffering from AN. These treatments, similarly to the guidelines mentioned above, do not point out specific practises for working with men.

NICE (2017) recommends anorexia-nervosa-focused family therapy for children and young people (FT-AN) for young people and children. Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED) is recommended for both young people and adults. The Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) with specialist supportive clinical management is also advised for adult care and treatment. Eating-disorder-focused focal psychodynamic therapy is indicated by NICE (2017) when patients do not respond to other treatments.

More recently professionals have been drawn towards implementing other therapeutic approaches including *third wave therapies* when treating EDs including AN, particularly when presenting with comorbidities (Kahl, Winter, & Schweiger, 2012; Linardon, Fairburn, Fitzsimmons-Craft, Wilfley, & Brennan, 2017). For example, but not limited to schema therapy (ST), narrative therapy (NT), and dialectical behaviour therapy (DBT). A brief description of these follows.

As mentioned, people with AN often develop into chronic disorders, which may be disabling and are difficult to treat (Fairburn, 2005). Patients typically hold rigid cognitive patterns (Lang et al., 2014), frequently display comorbidities (Steinhausen, 2009), and have often experienced trauma related risk factors, such as bullying (Guegen et al., 2012). ST was created to address “core” beliefs and maintaining coping strategies (Young, Klosko, & Weishaar, 2012), and has been found to be effective when working with people who suffer from AN (Munro, 2014; Waller, Kennerley, & Ohanian, 2007).

NT is also used with people who suffer from AN (Lock, Epston, & Maisel, 2005). Botha (2012) described AN as having an “unbounded sphere of influence over the lives of those whom it affects” (p.159). The process of narrative therapy helps individuals understand their experiences and life situations through externalisation. Externalising conversations can assist people in separating problems from themselves, thus limiting the impact of AN over their lives, as Lock et al. (2005, p.9) stated, “the person is not the problem, the problem is the problem”.

DBT was developed to treat patients with borderline personality disorder (BPD), and is a unique method incorporating a highly structured and systematised programme where therapist, and consulting team deliver life skills training enabling the client to live independently while managing high intensity emotions (Linehan, 1993). One of DBT’s strengths is its versatility across different presentations, hence it can be tailored to treating EDs (Comtois et al., 2007). DBT is based on a biosocial theory which postulates that during the developmental phases of childhood, BPD clients presented with emotional dysregulation, and were exposed to an “invalidating environment” (Linehan, 1993). Emotion dysregulation can lead to “dysfunctional response” patterns during emotionally challenging events (Crowell, Beauchaine, & Linehan, 2009, p.495). The biosocial theory, which DBT rests upon, has been “adapted” to EDs (Ritschel, Lim, & Stewart, 2015). For example, AN patients present problems with emotions which may appear in the form of inhibition or avoidance of feelings. The structure of DBT is effective in responding to “difficult to treat” EDs particularly in those who have dealt with the pathology for a number of years (Wisniewski & Kelly, 2003).

According to NICE (2017) and to the American Psychiatric Association (2006), CBT, interpersonal therapy, cognitive analytical therapy and focal psychodynamic therapy, are equally effective with AN (Danielsen et al., 2016).

Walsh (2013) corroborated previous investigations (Fairburn, 2005), affirming that given the seriousness, complexity and persistence of AN, establishing whether there are treatments for AN with a strong evidence base has been challenging. Moreover, Halmi et al. (2005) advised that the issue of elevated treatment dropout rates should be tackled first, as most outcomes are based on short-term enquiries and affect research results on evidence-based treatment.

### *Experience of treatment*

Rance, Moller and Clarke (2017) explained that sufferers seek holistic treatments, and that care which focuses merely on weight gain and food yielded negative “iatrogenic” (p.17) side effects as well as an increase in suicide rates. For instance, patients reported that these approaches to treatment were “compounding their obsession with weight and food” (p.16), interfering with their interest in the causes of their disorders leaving them feeling misunderstood (Rance et al., 2017). Patients reported that, suitable treatment encompassed the use of non-rigid or structured treatment protocols, and that care should be fitted around the individual (Eli, 2014; Smith et al., 2016).

### *Men’s experience of treatment for EDs*

Weltzin and colleagues (2012) conducted a quantitative study on men’s experiences of treatment for EDs. Although their research did not highlight specific similarities across genders, the consensus seemed to be that experience of treatment is not different. However, Weltzin et al. (2012) pointed out aspects of the treatment experience which men reported as being helpful. For example, addressing topics around sexual identity and sexual orientation, physical exercise, body appearance and muscularity, spirituality and the importance of all-male group therapy. These findings seemed in line with Copperman’s (2000) study reporting men’s disappointment with professionals’ competence within EDs services and a wish for their “maleness” to be recognised.

Robinson and colleagues’ (2013) qualitative study on men’s experiences of treatment for AN generated themes underlining the relationship between the self (being a man) and having an ED, and the importance of gender when in treatment. Their research seemed to show that the eight participants had different experiences and some of the emerging themes corresponded to themes which arose from studies focusing on females’ experiences. Robinson et al.’s (2013) study also confirmed the research conducted by Dearden and Mulgrew (2013) where men’s experiences of treatment highlighted the barriers to help-

seeking and to receiving support, such as long waiting lists, services developed around females' needs, and professionals' insufficient acknowledgement of the importance of gender during treatment.

Thapilyan, Mitchison and Hay (2017), conducted a qualitative study analysing autobiographies of men's experiences of treatment for EDs. Their results displayed negative and positive experiences of treatment. For example, perception of judgmental or unfriendly attitudes of professionals and lack of expertise and ignorance with regard to EDs in men were classified as negative experiences. Positive experiences were effective communication style, the environment and staff of services and treatment forms, such as group or individual therapy.

Qualitative and quantitative enquiries on males' experiences of treatment seem to be insufficient (Thapilyan et al., 2017). More attention to understanding each person's qualities, in order to tailor care and treatment to the specific needs, hopes and wishes of the person, is essential for more effective outcomes. As Greenberg and Schoens's (2008) study pointed out, men may have unique needs.

The current study sets out to explore participants' experiences adopting a holistic view in terms of the support necessary to aid AN sufferers' well-being. Underpinning this perspective is the ethos of the reflective CP practitioner where setting the focus on the individual's experience, mutual trust and respect remain central. No treatment fits all, and the therapeutic work is moved by collaborating with the client (together with other professional bodies).

## **2.4. Motivation to Change**

The focus of this thesis is men's experiences of MoC in relation to their journey with AN. Theories of MoC can be viewed as transcending existing ideas around the AN journey from its initial presentation to the recovery period. Given the above mentioned viewpoint, MoC will be addressed in this section.

Aiming to offer the reader contextual information, this section will start by explaining the difference between intrinsic and extrinsic motivation. It will then consider the relevance of MoC for EDs and for the CP field. A brief history of the literature of MoC will follow, leading to a critical literature review on MoC in EDs.

#### 2.4.1. *Intrinsic and extrinsic MoC*

“To be motivated means *to be moved* to do something” (Deci & Ryan, 2000, p. 54).

Prior to considering the literature on MoC in MH and EDs in more detail, it seems important to present the distinction between intrinsic and extrinsic motivation underpinning the Self-Determination Theory (SDT) (Deci & Ryan, 1985).

The SDT proposes that there are different kinds of motivation (Deci & Ryan, 1985, 2000). “Intrinsic motivation” or “autonomous motivation” (Carter & Kelly, 2015, p.76) involves doing something because it is “inherently interesting and enjoyable” (Ryan & Deci, 2000, p.55) and is fuelled by subjective motives. “Intrinsic motivation” can be used to assess readiness to change which may predict treatment dropout rates and successful recovery (Thaler et al., 2016). External or “extrinsic motivation” is when a person is driven by external “prods, pressures, or rewards” and is moved to attain “separable outcome” (Deci & Ryan, 2000, p.55) that may differ from his or her personal inclinations.

Successful treatment and recovery appears to be linked to the internal, autonomous motivation of the sufferer (Deci & Ryan, 2000). This includes motivation which is “extrinsic” as long as it presents with “personal endorsement and feeling of choice” (Deci & Ryan, 2000, p.60). As individuals develop from childhood, their drives are less intrinsically initiated and more restricted by social demands, and therefore people are not driven solely by the satisfaction of an activity itself. Deci and Ryan (2000) explained that “extrinsic motivation” can be conceptualised as existing on a spectrum and depends on the person’s extent of autonomy within the motivation. For example, a person might be motivated to achieve a goal to avoid a punishment, or in contrast might be motivated to acquire more knowledge on a topic of interest. Both motivations involve intentionality and autonomy (yet to a varying degree) and have an “instrumental value” (Deci & Ryan, 2000, p.60).

#### 2.4.2. *Relevance of Moc for EDs*

Motivation seems to have psychological, environmental and biological components (Deckers, 2013), and “can be understood not as something that one has but rather as something one does. It involves recognising a problem, searching for a way to change, and then beginning and sticking with that change strategy.” (Miller, 1999, p.1).

Studies showed that MoC in patients with EDs is key for effective treatment response and treatment outcome, and ultimately for recovery (Hoetzel, von Brachel, Schlossmacher, & Vocks, 2013; Nordbø et al., 2008; Pauli et al., 2017; Vall & Wade, 2015). In most cases, AN is an “ego-syntonic illness” whereby sufferers’ perception of the experience is congruent with their values, and therefore recognise it as favourable (Aspen, Darcy, & Lock, 2014; Gregertsen et al., 2017, para. 1). People who experience AN, might initially feel power, in control and, mentally and physically strong; these may confer a sense of gratification and success (Fox, Larkin, & Leung, 2011; Nordbø, Epsest, Gulliksen, Skårderud, & Holte, 2006). Concern and intervention of professionals, parents and carers can be in sharp contrast to the sufferers’ perceptions. Sufferers reported fearing the loss of their acquired achievements as well as loss of control, leading to resistance to treatment (Aspen et al., 2014). AN can drive sufferers to sacrifice important areas of their life and may compromise their physical health, in some cases with irreversible consequences. It usually takes time before a person begins connecting to thoughts regarding health and the recovery process, and this can coincide with a perceived loss of control (Williams & Reid, 2012). Although the idea of recovery allows sufferers’ drive to change trajectory, motivation can “fluctuate” making them ambivalent about their wish to recover or resistant to changing their behavioural patterns (Kitson, 2012, para.1). Letting go of control is a trying task and the ability to change behaviours often does not match MoC or wish to recover (Kitson, 2012). Treatment dropout rates are affected by ambivalence in motivation and by undertaking treatment when pressured by external demands coming from the family or professionals (Price-Evans & Treasure, 2011). Autonomy in patients’ motivation can predict long-dayterm outcomes; it provides an internal locus of control which implies control over choices, enabling individuals to be active agents within their struggles (Nordbø et al., 2008).

MoC is an essential aspect of individuals’ journeys with AN, including recovery and treatment (Hoetzel et al., 2013). It is paramount that individuals experiencing AN, families, carers, professionals and their wider support network improve their own understanding of the experiences of MoC in order to identify signs and offer their support accordingly.

#### *2.4.3. Relevance of MoC in EDs for counselling psychology*

CPs may belong to the specialised services’ MDTs which are responsible for treatment of people who are diagnosed with EDs, or may provide psychological therapies in private settings (Tchanturia, 2015). Clinicians may also offer group and individual therapy to sufferers, to their family members and carers. Investigating MoC further appears to be fundamental in improving understanding, and devising new strategies to help sufferers,

engaging research based evidence into psychologists' practice (HCPC, 2015). Identifying, exploring and understanding the qualities of MoC for people who experienced AN seems relevant to the CP field to support individuals, families and carers in promoting its development. Hence assessing readiness, identifying the positive and negative drives towards change, appreciating barriers and encouraging positive motives is key. Acceptance, encouragement, and empathy can help to support the individual throughout the journey with AN, including during the phases characterised by ambivalent feelings towards change (Kitson, 2012). Therefore, enhancing and deepening CPs' understanding of the experiences of MoC appears central to informing their work, refining their therapeutic approach, and to building trusting therapeutic alliances support individuals in their struggle (HCPC, 2015; Rance et al., 2017; Robinson et al., 2013).

#### *2.4.4. Research on MoC in EDs*

This section will firstly focus on MoC within EDs. It will critically present the way MoC has been conceptualised as an assessment used to devise suitable treatment for individuals with EDs. It will also look at the way it has been researched and applied in the context of EDs. Lastly, it will present the rationale for the current study.

In the context of this study, the literature review on to MoC will attend to EDs in general. Although some studies considered aspects of motivation in relation to one kind of ED, it was observed that the literature with a narrower focus on MoC in AN was limited, and studies on MoC have often been conducted focusing on EDs in general.

The following combinations of search terms were employed in the process of preliminary research: Anorexia Nervosa and MoC, and EDs and MoC.

#### *Assessing MoC in EDs – “quantity”*

Assessment of MoC may predict treatment outcome in MH issues such as substance abuse and EDs (Miller, 1999; Vall & Wade, 2015). Prochaska and Di Clemente (1982) pioneered with the Transtheoretical Model of Change (TTM), showing the implications of fostering the motivational force in patients with addictive behaviours. They identified five stages of change: “precontemplation” (no thoughts about change), “contemplation” (thoughts around change are present), “preparation” (intentions for change are being set), “action” (actively making changes), and “maintenance” (relapse prevention). They argued that, for the model to yield successful results, interventions must be tailored to the client's existing stage, as



stages of change can predict commitment to therapy, recovery, relapse and maintenance (Prochaska & Di Clemente, 1982). Prochaska and Velicer (1997) contended that progress through the stages is sequential however, before reaching “maintenance” and “termination”, revisiting earlier stages is expected.

#### *Application of the TTM to EDs*

The TTM has been applied to EDs’ evaluation and treatment (Wilson & Schlam, 2004; Dray & Wade, 2012; Clausen et al., 2013). This model provided the theoretical framework of “quantity” or strength of motivation, from which other psychologists developed measures to assess MoC (Nordbø, et al., 2008). Weinstein, Rothman and Sutton (1998) proposed that, for a stage theory to be valid, allocation to a category must be unequivocal. The TTM’s assignment of people to stages, might not represent the dynamic nature of their change process (Wilson & Schlam, 2004). In several questionnaires employing the TTM, patients are considered to be in “action” when they have quit the behaviour in question for a period of six months, for others “action” denotes having begun to engage with the problem (Abrams et al., 2003; Sutton, 2001). Also, the TTM does not consider the underpinnings of motivation. For instance, it implies that decision-making is always made in full awareness, not accounting for more subtle transformations in motivation which are not informed by a conscious process. Moreover, as Robinson and Berridge (2003) reported, habits can be engrained through the internalisation of the recurrence of reward and punishment feedback, which the TTM seems not to take into account.

In response to the ambiguity of allocation to stages research, professionals devised the Readiness to Recover Interview (Rieger et al., 2000) as a continuous measure rather than algorithms. This however, does not avoid confusion as people have been assigned to different stages simultaneously (Wilson & Schlam, 2004). Consequently, questions of overall validity and applicability of the TTM to clinical cohorts have surfaced. The Anorexia Nervosa Stages to Change Questionnaire (ANSOCQ) was developed by Rieger and colleagues (2000) in an attempt to include a larger quantity of behaviours, and their respective intensities. This measure seems to be reliable and valid to assess stages of change in relation to specific reported symptoms. Nevertheless, it generates a global score allocating individuals to one global representative stage, which may not characterize the complex experiences of sufferers (Hoetzel et al., 2013). Geller, Cockell and Drab (2001) developed the Readiness and Motivation Interview (RMI), a semi-structured interview to assess MoC. The RMI presented with three stages, “precontemplation”, “contemplation” and “action-maintenance”, and patients can belong to one or more concurrently. The RMI (Geller et al.,

2001) allows to elicit rich descriptions during the assessment and offers opportunities to enquire at depth. Although this qualitative assessment appears to be a valid measure, capturing ambivalence in the ED population, it demonstrates that stages assigned to patients are not clear-cut making it problematic to match an ad hoc intervention. On the other hand, other investigations have shown that practical and brief measures may better predict outcomes. For instance, Treasure and colleagues (1999), found that participants who completed a TTM “stages” questionnaire in its entirety were less likely to drop out of treatment. Quantitative questionnaires, such as the ANSOCQ (Rieger et al., 2002), the Bulimia Nervosa Stages of Change Questionnaire (BNSCQ) (Martinez et al., 2007), and the Readiness and Motivation Questionnaire (Geller, Brown, Srikameswaran, Piper, & Dunn, 2013) systematically assign a stage of change to each presenting symptom of the patient, therefore acknowledging that motivation in EDs can be multi-faceted and complex.

As West (2005) noted, models based on stage theories are founded on “arbitrary divides” (p. 1036), which may not reflect subjective experience. Moreover, they do not seem to explain more rapid changes in individuals, less coherent decisions, or changes elicited by seemingly minor triggers (West, 2005). Furthermore, these measures focused on the recognition of motivation in order to provide a specific cure. Hoetzel and colleagues (2013) critiqued the aforementioned quantitative measures for oversimplifying circumstances. Finally, the measures above have been designed to conduct studies with women; they examined a vast majority of female samples, only including 2 per cent of males at the most, with predominantly quantitative outcomes.

More recently, Wade et al. (2009) confirmed that a higher motivation at base line predicted decreases in EDs. Similarly, those participants whose motivation shifted towards wanting to recover, also showed decreased level of EDs. This study suggested that further exploration of MoC within AN is needed, as it identified significant predictive results between higher motivation and decreased levels of pathology. However, the study included only two men out of a total of forty-seven participants. Although yielding important predictive results, exclusively quantitative methods meant that the study did not shine a light on the subjective experiences of the participants.

It looks like attention to the type of motivation, and to the sources of the willingness to recover is needed, aiming to tailor the quality of support provided.

#### Assessing MoC in EDs – “quality”

Deci and Ryan (1985, 2000) built on previous research, maintaining that motivation is multi-faceted and can be evaluated according to its “quality”. This idea invited scholars to ponder about the properties of motivation and not just on its amount. Deci and Ryan (1985, 2000) acknowledged the contrast between internal and external goals in relation to mental functioning and psychological well-being. This suggested that unceasing change is present only if the motivation is autonomous or intrinsic (Carter & Kelly, 2015; Nordbø et al., 2008). Vansteenkiste and colleagues (2005), drew upon Ryan and Deci’s SDT (1985, 2000) which asserted that “autonomy and volition” in independent choice-making are essential in promoting personal change. They also explained that, rather than the “intrinsic” MoC (e.g., enjoyment and excitement), the *degree of internalisation* of change reflected the quality of motivation, suggesting that the individuals’ accepting of the importance of personal change is essential. Vansteenkiste and colleagues (2005) maintained that identifying with MoC (i.e., the degree to which change represented a true expression of the person’s values) was in contrast with “controlled motivation”. Controlled motivation includes “introjected motivation” (i.e., feeling internally pressured) and “external motivations” (i.e., rewards and punishments coming from the environment around the individual). The researchers further asserted that, both quality of motivation and its quantity need to be accounted for, supporting previous studies. Vansteenkiste et al. (2005; Vandereycken & Vansteenkiste, 2009) found that participants who decided to begin treatment and persisted, made greater progress and were less inclined to dropout, compared to those who were coerced into making choices. Once more, their studies only yielded quantitative data, focused on women and was based only on short-term outcomes. It may be interesting to assess long-term effects to evaluate this study’s reliability. The individual experience of EDs is often characterized by a sense of ambivalence about change (Serpell et al., 1999; Nordbø et al., 2006; Jenkins & Ogden, 2012; Williams & Reid, 2012; Dawson, Rhodes, & Touyz, 2014). This fluctuation in motivation can be conceptualized as a continuum represented by two polar extremes: wanting to recover to be healthy and functioning again, and not wanting to change (including not wanting to give up eating habits, or to let go of control, or of a weight loss plan). Understandably, individual differences may emerge in sufferers’ experiences. Inconsistent feelings can make it hard for sufferers to build a therapeutic, or a parent-child relationship based on trust and honesty (Spivack & Willig, 2010). Forming solid friendships and nourishing romantic relationships, and maintaining a steady family life, can become overly demanding (Arcelus, Haslam, Farrow, & Meyer, 2013; Brown, Mountford & Waller, 2013; Dimitropoulos & Klopfer, 2009; Laghi et al., 2017). However, supportive relationships are vital in recovery (Treasure, Smith & Crane, 2016). Therefore, a careful appreciation of the motivation experienced by sufferers can benefit carers, researchers and professionals in understanding the subjective reality of living with these illnesses. Enquiries demonstrated that at the pre-contemplation stage, an

“emotional bond” and “the agreement on collaboration” predict a strong therapeutic alliance at later stages of treatment (Mander, Teufel, Keifenheim, Zipfel, & Giel, 2013, para. 11; Wade & Vall, 2015). Mander and colleagues (2013) corroborated that MoC is susceptible to instabilities in patients. Although change is the individual’s responsibility, psychologists can assist in recognising problems, considering change options, fostering one’s confidence and competence to change, developing and implementing a plan, and in maintaining action strategies, using therapies that support and encourage motivation (Center for Substance Abuse Treatment, 1999; Adams & Leary, 2007).

### Assessing MoC in EDs – “content”

Besides the “quantity” (Prochaska & Di Clemente, 1982) and the “quality” of motivation (Ryan & Deci, 2000, 2008), Nordbø and colleagues (2008) suggested that the “content” of the drive to change or desire to be healthy is essential to inform a “comprehensive framework” (p. 636) of understanding. ED clients can be ambivalent around recovery and change, and may simultaneously want to recover whilst not being driven to change. Nordbø and colleagues’ (2008) study centred on participants’ “wish to recover” (p. 635) as a precursor to the intention to modify behaviours. The wish to recover does not necessarily represent an *active* ambition to make amendments to behaviours. The report broadened the notion of “motivation to change” (Nordbø et al., 2008) and systematically examined what the patients describe as driving their desire for recovery. Through thematic analysis, outcomes revealed how subjective perception of events, social conditions, physical sensations, mental awareness, “limitations of goals” and hopes for the future, could make AN patients want to recover without there being a determination to make the change. Whilst previous enquiries concentrated on an active intention to bring about change, Nordbø and colleagues’ (2008) research differentiated between patients being ready to make variations in their behaviours and those wanting to be healthy again. The analysis was based on Swedish women’s experiences and did not seem to consider the impact of other MH difficulties or past experiences, on the participants’ accounts.

## 2.5. Rationale for the Current Research to Lead in to the Study

When considering the literature on MoC in relation to AN, there seems to be a wide consensus on its relevance in terms of effective treatment and care (Hoetzel et al., 2013). Assessing, and fostering MoC, can be helpful in predicting treatment dropout rates, to encourage patients towards their goals, and for effective treatment. Thus far, most of the research on MoC in EDs seems to be centred around quantitative constructs and has mainly

focused on women (Treasure et al., 1999). Although quantitative outcomes have yielded interesting inferences in understanding MoC in the field of EDs, nomothetic data may not capture the deeper experiences of participants, ambivalent thought processes, and individual differences (Nordbø et al., 2008; Paulson-Karlsson & Nevenon, 2012).

Human experiences are extremely diverse, and quantitative enquiries may leave many questions unanswered. It appears that MoC varies greatly from person to person and across time (Dawson et al., 2014). Fogarty and Rajman (2016) highlighted that during the phases of recovery from EDs, individuals' needs differed, thus endorsing the view that no single human experience seems to match that of another individual. Qualitative research may assist in capturing inconsistencies and fluctuations within the experiences of interviewees. Nordbø and colleagues (2008) responded to the need for a more profound understanding of experiences of MoC. They addressed the phenomenon, nevertheless their analysis focused on Swedish females' experiences only. Vall and Wade (2015) advised that a deeper understanding is needed in order to help people who suffer from EDs to recover. They stated that research should be directed towards ways of improving motivation in patients and agreed that there is no universally valid treatment model which can be used to treat AN. Qualitative constructs also offer researcher possibilities to explore experiences in depth.

The literature on MoC in EDs seems to reflect the absence of a more profound and nuanced understanding of the experiences of individuals. Researchers and professionals are heavily relying on positivist constructs to inform their practice. An appreciation of variation in experiences is required to respond to the increasing need for specialist services which provide excellence in care to male service users, their families and carers.

Furthermore, an evident focus on women has characterised research in EDs, which is echoed in MoC research findings in the context of EDs and AN. There seems to be a lack of qualitative studies on MoC in EDs conducted with males. Developing further evidence-based practices is key to help sufferers and those around them. More attention to other populations (such as males and LGBTQ) is required to meet the needs of individuals who are stigmatised, reluctant to seek help, misdiagnosed.

Given the large amount of research on women in the field of EDs and MoC related to AN, this study seeks to shed light on men's experiences to promote awareness around men who struggle with EDs, in order to discredit the belief that AN is a 'women's problem'. Diekmann and Eagly (2008) stated that when people expect role changes in society, they adapt to accommodate the changes in a functional and positive manner.

According to Fogarty and Ramjan (2016), treatment deemed suitable involves accessible and individualised care and support to meet the person's specific needs. A qualitative research method has been selected to give a voice to the experience of those who are, or have been directly, involved with AN.

In conclusion, a qualitative exploration of men's experiences of MoC in relation to their journey with AN will follow. This will involve analysis and interpretation of interviews conducted with men who reported an experience of AN. To my knowledge no qualitative enquiries have focused on men's MoC in relation to their experience of AN.

### **3. Chapter Two: Methodology**

#### **3.1. Introduction**

In this chapter I seek to illuminate how do men experience MoC in their journey with AN.

I first describe the research aim before clarifying the qualitative research methodology of the current study. I then discuss my epistemological standpoint in relation to the chosen method. Lastly, I explain the various dimensions of my research design, including consideration of Yardley's (2000) guidelines for validity. Use of reflexivity (in italic font) will be interwoven throughout and will also be considered in the final section of this chapter.

#### **3.2. Research Aim**

In this study I explore the participants' experiences of MoC including but not limited to what drives, impedes and challenges their journey with AN. As mentioned in the Introduction, I hope this piece of research will help sufferers, professionals, family members, carers and the wider public to connect to these experiences and gain insight into the lives of these men. A greater understanding of men's experiences of AN could prompt development of care treatments and might foster awareness and compassion around the AN experiences, contributing to the reduction of stigma experienced by men with EDs.

*I chose this research topic as I feel invested in it on a personal and professional level (section 3.12.2.). My awareness and assumptions are informed by what I have experienced and witnessed first-hand, as well as by the knowledge I gained from the wealth of literature on AN. I accept that my own lived perceptions may prescribe the course of the research at various stages. Thus, I intend to use reflexivity to remain open and curious about participants' experiences which is fundamental to the Interpretative Phenomenological Analysis (IPA) methodology I use in this study. I also propose to reflect on how I use my experience and prior knowledge in the research process.*

#### **3.3. Rationale for Using a Qualitative Research Paradigm**

##### *3.3.1. The limitations of quantitative methodologies for EDs*

Positivist research methods account for the majority of the existing body of evidence on motivation in people with AN (and more broadly with EDs) (section 2.4.4.). Through the use

of questionnaires, studies have tried to allocate patients to specific motivational stages, in order for clinicians to predict whether they were committed to recovering or at risk of relapse, thus adjusting treatment accordingly. Researchers have sought out strategies to assist individuals in directing their motivational drive towards recovery and treatments. Although quantitative methods have contributed to the wealth of literature on EDs and have enabled progress in care, protocols generated by nomothetic enquiries have sometimes failed to acknowledge the incidence of EDs in men. Moreover, standardised treatments have sometimes not recognised underlying issues within individuals, which may contribute to the perpetuation of the ED (Bruch, 1978).

Quantitative research sets out to produce positivist outcomes, directed towards generalisability across populations. This may mean that quantitative methods potentially lose sight of the individual. For example, people may share similar beliefs but their underlying reasons for holding these beliefs may be different. Therefore, quantitative approaches may fail to generate a holistic representation of each person's experience (Nevon & Bromberg, 2000), which might be needed to understand AN, its meaning for each sufferer, and not merely symptomology. Furthermore, in quantitative investigations, the researcher is independent from the data and bound to more rigid data collecting, analysing and interpreting processes. Consequently, enquirers may overlook grey areas and aspects of data that are helpful for developing new knowledge, and possibly effective treatment (Jarman, Smith, & Walsh, 1997)

### *3.3.2. Suitability for qualitative research*

The choice of the research method must be tailored to the research question (Willig, 2013). This research is concerned with exploring individuals' authentic experiences of their subjective reality. Furthermore, this study aims to understand the development of participants' motivation and their reactions to change.

In the endeavour to develop and complement the ED research to date, exploring men's subjective experiences through qualitative research can provide new insights, as "respondents may bring concerns and views not previously considered" (NHS, 2017). Qualitative research is flexible and allows the researcher to explore sensations, cognitions, and behaviours which emerge through the dialogue. Qualitative research highlights the researcher's subjectivity and sensitivity as helping to achieve deeper insight into participants' sense-making of a phenomenon (Henwood & Pidgeon, 1992). Barker, Pistrang, and Elliott (2002) advised that qualitative methodology can unearth unexpected narratives because



participants are not confined to a pre-established selection of answers, as in the case of questionnaires. Moreover, a “more meaningful participatory role” in research, may empower individuals, as there is freedom and choice in revealing their experiences (Willig & Stainton Rogers, 2017).

It might be useful to adopt an inductive method to extend and strengthen researchers’ awareness and understanding of EDs in men, not only because enquiries into men’s experiences of the journey with AN are very limited. The male population seems to be sometimes overlooked when EDs are considered. Receiving little acknowledgement appears to have led male ED sufferers to experience stigmatisation or discrimination (Strother et al., 2012). Therefore, inviting male participants to express their understandings through extended conversations, is a way to give voice to this population, when compared to quantitative methods.

Despite the increase in qualitative enquiries within the field of EDs, these are still very few compared to quantitative investigations; especially with male participants. The value of qualitative enquiries for EDs has been acknowledged by various researchers (Hepworth, 1994; Nichols, Fogarty, Hay, & Ramjan, 2016). EDs are complex, and as Fogarty and Ramjan (2016) stressed, individuals’ experiences and needs differ during the phases of recovery. Moreover, Jarman et al., (1997) suggested that the clinical field of EDs could benefit from qualitative research to help improve treatment plans, due to their view that there are many aspects and experiences within the ED journeys which are underexplored. It may be valuable to gain insight into individuals’ subjective realities by remaining close to their descriptions through the use of an exploratory approach. McLeod (2010) further maintained that the present era in counselling and psychotherapy research is beginning to move beyond legitimisation and verification and into a “stage of discovery, adaptation and innovation”: a “form of knowing that is particularly attuned to the study of how aspects of social life such as counselling and psychotherapy are constructed and reconstructed” (McLeod, 2010).

### **3.4. Ontological and Epistemological Position**

#### *3.4.1. Ontological stance*

To consider and explain my beliefs about knowledge production, I will first clarify my position in relation to a spectrum which sees realist and relativist ontological positions as extremes. I believe that participants’ descriptions are consequence of their lived experiences, and therefore a representation of their realities. Experiences and the circumstances described

are not a mere construction of language, rather I believe that they do exist in their own right. Although cultures and contexts may influence participants' accounts of their experiences, situations occur regardless of one's perceptions of these. Therefore, I do not adopt an extreme relativist position. On the other hand, my belief that individuals do not maintain a neutral stance in their interpretations does not fit with an extreme realist position. It is my view that the descriptions offered by participants are inherently integrated by their individual readings of situations depending on their pre-understandings and assumptions. Likewise, their accounts may be subsequently 'tainted' by the researcher's expectations and prior knowledge.

My ontological beliefs adhere to critical realism. A critical realist ontology stresses that the world exists independently of perceptions, theories and context (Phillips, 1987). Therefore, there is variability between people's experiences, because each individual appreciates distinctive parts of the same reality. The goal of my research is to focus on the depth of lived experiences of the participants. Consequently, while conducting my study I will be interacting with participants' "experiential claims and concerns" (Larkin, Watts, & Clifton, 2006, p.104) whilst trying to enter their worlds and look at the world through their eyes (Willig, 2013). The aim of this study is to explore men's idiosyncratic experiences of MoC in relation to recovery from AN. Consequently, it is important to consider the impact of the wider context surrounding participants' subjective experiences on their intentions to change in AN. I believe that, although stemming from the individual participants, experiences of motivation are collected throughout their involvement and interaction with the world.

#### *3.4.2. Epistemological standpoint*

Epistemology is closely related to the methodology of research (Willig, 2013) and is "concerned with the theory of knowledge" (Grix, 2002, p.177), and therefore, with "the possible ways of gaining knowledge" (Blaikie, 2000, p.8). In keeping with critical realist ontology, this study is epistemologically grounded in the contextualist stance (Larkin et al., 2006). "Contextual constructionism seeks to locate claims-making within its context" (Best, 1995, p. 831), this means, "the human act in context" (Tebes, 2005, p.216). Therefore, this way of gaining knowledge is closely linked to the historical moment, to the societies involved and the determined "claim-makers" (Thibodeaux, 2014). As Braun and Clark (2013) asserted, knowledge is determined by the contexts of the participants and the researcher, therefore interpretation is influenced by multiple truths. The contextual constructionist position assumes that all knowledge is context and perspective dependent, where differing perspectives provide insight into the same phenomenon (Willig, 2001).

The way MoC comes about and unfolds may be perceived in as many ways as there are participants (Elliott & Timulak, 2005). Willig (2013) explained, this position assumes that all knowledge is “contextual and standpoint dependent”, therefore each experience stems from a unique perspective and will accordingly produce distinctive knowledge. This position broadens the perspective of the researcher when pursuing the understanding of participants’ reported experiences, by accounting for social, cultural, psychological and theoretical contexts (Willig, 2013). Moreover, knowledge is further developed together with the researcher. Through the use of open-ended questioning and allowing participants to lead, my role is to provide an empathic, non-judgmental setting which can facilitate the participants’ access to information. I seek to explore the perspective of the individual – in a “third-person’s perspective” - from my “first-person position” (Larkin & Thompson, 2012). This will allow me to acquire the viewpoint of the “person in context” (Larkin et al., 2006). The information generated by the participants’ recollections is the knowledge that this study hopes to obtain (Willig, 2013). Fade (2004) maintained that the researcher is the primary analytical instrument in interpretative phenomenology. By acknowledging my personal beliefs and standpoint, and embracing the view that understanding requires interpretation, I appreciate that this position intends to “provide a critical and conceptual commentary upon the ‘sense-making’ activities” (Willig, 2013, p.173). As Smith and Osborn (2015) explained, the process of interpretation involves a double hermeneutic, whereby the researcher “is trying to make sense of the participant as the participant is trying to make sense of what is happening to them” (p.41).

### *3.4.3. Epistemological reflexivity*

Contextual constructionism “accepts the inevitability of bringing one’s personal and cultural perspectives to bear on research projects. In fact, the empathy provided by a shared humanity and common cultural understanding can be an important bridge between researcher and participant and a valuable analytic source” (Madhill, Jordan, & Shirley, 2000, p.10). Contextual constructionism places attention on the process of reflexivity. Acknowledgement and awareness of the internal processes of the researcher and of the dynamics between the researcher and the participants, mark one of the fundamental elements of phenomenology as being a means to connect to people’s experiences (Smith et al., 2009). Thus, the IPA researcher plays an active role in interpreting the data gathered: I want to get closer to the world of the participant, but I also rely on and acknowledge the impact of my pre-understandings. I therefore draw from a double hermeneutic: an “empathic hermeneutic” and a “questioning hermeneutic” (hermeneutics of suspicion) (Smith & Osborn,

2003). Interpretation is fostered by “simple descriptions” and is aided by a tolerance for ambiguity, which helps avoid premature closure (Packer, 1989).

### **3.5. Methodological Considerations and Research Methods**

#### *3.5.1. Methodological considerations*

Husserl (1859-1938) can be considered the “father” of phenomenology (Benhke, 2011). He understood phenomenology as the “world as it presents itself to people” (Willig, 2013, p.95) in its unaltered form. Husserl (1936) explained that the world is made up of objects and subjects which cannot be separated, therefore individuals are an inextricable part of the world. According to Husserl (1936), consciousness is a critical element within the lived experiences, as people can give meanings to phenomena through intentional awareness, depending on how they interact with the world. Therefore, consciousness is not necessarily part of the world, but can be thought of as a “constitutive presupposition for experiencing any part of the world” (Benhke, 2011, para. 3). Moreover, Husserl claimed that, to generate knowledge, people could experience the world in a given environment by “transcending” or “bracketing” pre-understandings or assumptions, arriving at the “essence” of what is experienced (Husserl, 1936), a process called “reduction”. According to Husserl, “essences” can justify why different people may experience situations in different ways, and why a single individual may perceive one phenomenon in various ways.

Husserl’s (1931) transcendental phenomenology underpins the descriptive phenomenological research method. Transcendental phenomenology recognises that peoples’ views and pre-conceptions in interpretations of phenomena can be reduced to reach “phenomenological purity” (Husserl, 1931). In line with this thought, Giorgi and Giorgi (2008) agreed that the phenomenological method is a descriptive form of enquiry and that interpretation is a type of description.

Heidegger (1962), developed Husserl’s (1970) ideas, arguing that interpretation is key in the phenomenological method because we relate experiences to their context and to our pre-understandings. Heidegger (1962) proposed that we are beings in the world, thus introducing the idea that it is human “consciousness” that makes the world meaningful and not merely existence (Drummond, 2007). Heidegger’s ideas gave rise to the interpretative phenomenological methods, or hermeneutic phenomenology, which are at the base of IPA (Smith, 1996). Heidegger stated that it is not possible to separate an interpretation of

something that is presented to a person, from his or her pre-assumptions as both are integral to making sense of a phenomenon and its interpretation.

Merleau-Ponty's view (1962) resonated with Heidegger's understandings of being-in-the-world and expanded the issue by "locating" our perspective and interpretation of the world. He explained that humans perceive themselves as different from everything else and that the nature of our relationship with the world is "embodied" (Smith et al., 2009). From this perspective, the body is not regarded as one of the objects in the world, but rather as a means of communication with it (Merleau-Ponty, 1962).

I believe that knowledge is comprised of subjective "lived experiences" based on occurrences or situations which exist in the world which are "the product of interpretation" of individuals. Although "constructed", these interpretations are "flexible" and "real" to those who have the experience (Willig, 2013). As Smith (1996) argued, insight into participants' worlds is "partial and complex", and it is the result of a combination of the participants' accounts and the researcher's interpretation. I attempt here, to produce an analysis as 'close' as possible to the descriptions of the people who took part in the study.

### *3.5.2. Research methodology*

#### *Interpretative Phenomenological Analysis*

Interpretative Phenomenological Analysis (IPA) is a qualitative research approach created by Jonathan Smith. IPA intends to capture the experiential, qualitative aspects of people engaging with the world by drawing upon hermeneutics, phenomenology, and idiography, to understand the lived experience in any given environment (Willig, 2013; Pietkiewicz & Smith, 2014). As IPA seeks to obtain insights into "participants' psychological worlds", it is a method devised specifically for psychological research (Willig, 2013). According to Larkin and colleagues (2006), successful IPA entails "giving voice" to participants' subjective realities and "making sense" of their revelations. This is achieved through the researcher's interpretation, adopting a psychological view, and accounting for context. IPA is committed to idiographic analysis and is interested in the nature and essence of the phenomenon under scrutiny (Gee, 2011). IPA endeavours to offer a "detailed and nuanced analysis of the lived experience" of individuals and how they develop their knowledge (Willig, 2013, p.99). In addition to exploring individual accounts, this methodology allows deep exploration of themes that surface across and within interviews, therefore highlighting convergences as well as divergences amongst the participants' experiences.

### *Rationale for using IPA*

Given the research objectives to explore participants' experience of MoC in AN, IPA, with its focus on understanding people's lived experiences, would support the study aim.

Furthermore, IPA suits the objectives of this research because it permits a close examination of personal experiences and the meaning that people attribute to these (Smith et al., 2009). In addition, Drummond (2007) highlighted the importance of placing emphasis on social constructs as well as on experiences when studying EDs in men. An 'external' enquiry, such as a quantitative study, would not permit the researcher to understand and appreciate the phenomenon in the way the participants lived, experienced, and made sense of it (Gee, 2011). Therefore, quantitative or other qualitative based enquiries seem to be less suitable to reach the core, and the more internal experiences of individuals.

### *3.5.3. Consideration of other qualitative methods*

#### *Grounded Theory*

Grounded Theory (GT) allows researchers to study basic social processes and is directed towards a more conceptual and explanatory level of analysis (Willig, 2013). IPA however, is interested in the nature and essence of lived phenomena. AN is an extensively researched area, with a plethora of existing theories therefore, I do not intend to devise a new theory. My interest is to explore how men make sense of their MoC, and to compare these accounts to pre-existing theory through uncovering themes across participants' interviews. Hence, GT is not a preferred method of enquiry for the present study.

#### *Narrative Analysis*

Narrative Analysis (NA) is interested in the meaning-making of lived experiences. It is founded on social constructionism and attends to the "ways in which people organise and bring order to experience" (Silver, 2013). IPA seeks to "capture the essence and nature of the phenomena" (Willig, 2013, p. 99) directing attention beyond the participant's construction of the lived experience, thus falling more in line with the purpose of the proposed study. NA was not considered a suitable choice for the present research, as it was not consistent with my epistemological stance.

#### *Foucauldian Discourse Analysis*

Whilst IPA is based on the interpretation of experiences of individuals, Foucauldian Discourse Analysis (FDA) places emphasis on the relationship between discourse and people's subjectivity (Willig, 2013). Additionally, FDA focuses on the function of language in constructing social and emotional meanings for individuals (Willig, 2015). Eatough and Smith (2008) recognised that the emotional aspects of experiences can impact on language, however the authors acknowledge that discursive analysis may fail to pick up on the emotions. FDA does not seem fitting for this enquiry, which is aimed at capturing the idiographic phenomenology of motivation. Eatough and Smith (2008) stressed that these emotions can be elicited and emerge irrespective of the language used. Whilst taking into account culture, historical and social background, IPA's purpose is to shed light on the experiences of individuals (Eatough & Smith, 2008). IPA was chosen over FDA.

*In line with my background as a CP trainee, qualitative methodology resonates with me, as the subjective experience of the individual and its idiographic value are regarded as paramount. As a future CP, I firmly believe that collaboration with the client is essential in order to appreciate the context and circumstances he or she is experiencing. Acknowledging the uniqueness of each human experience is critical in effectively tailoring the care and treatment to the needs and wishes of the person. Moreover, CP practice centres around the individual's thoughts, feelings, behaviours, beliefs, perceptions and values (Douglas, Woolfe, Strawbridge, Kasket, & Galbraith, 2016).*

### **3.6. Pilot Study**

A pilot study conducted with one participant helped me familiarise myself with the interview process, to recognise possible pitfalls and assess the interview schedule's effectiveness. This was an opportunity to gain insight regarding the participant's reactions to the questions and to acquire feedback following the interview, thus encouraging my reflexivity.

#### *Participant*

A man who had an experience of AN and defined himself as "recovered", took part in the pilot study. I informed him that he was taking part in a preliminary interview on "MoC in relation to his experience of AN" as part of my doctoral study.

#### *Data collection*

The interview was conducted via Skype video call and lasted for forty-eight minutes. Upon conclusion, I asked for the participant's feedback on the questions and his experience of our interaction.

### *Interviewee's feedback*

The pilot interview yielded positive results. The dialogue between myself and the interviewee ran smoothly. I enquired whether the interview questions had unearthed difficult thoughts or elicited unwanted or unmanageable emotions. The interviewee replied that the questions had not generated undesirable thoughts or feelings. He reported that the questions had made him consider his experiences from angles he had not accessed before or that he maybe had forgotten about. He added that the interview helped him connect to some thoughts which he had assumed were not linked to his journey with AN. He said he hoped to address these idea in the future with his therapist. The interviewee told me he felt challenged by some questions and that he would have liked to explore his thoughts of AN more extensively during our conversation, such as his interpretations around the reasons why he experienced AN.

*I found that I the pilot study process had helped me get a flavour of what my feelings and thoughts regarding the interviewing process would be like. I had anticipated struggling between keeping focused on the questions and the experience of the participant, and monitoring his well-being. Instead, I felt calm and did not find the interview process arduous. During the interview, I noticed that I would have wanted to enquire further regarding certain emerging aspects that the participant made reference to. However, I reflected that such a dynamic is to be expected as interviews unfold. In keeping with the validity criteria (Yardley, 2000) and endeavouring to uphold the present study's reliability, whilst enabling the participant to take the lead, I chose to follow the interview schedule and prompts closely.*

This pilot interview was based on one participant only, and therefore, although staying mindful of his experience, upon concluding each interview that followed, I asked participants to comment on the interview experience.

*Although I was aware that around half of the interviews would have to be conducted via Skype video calls for reasons explained in the section on Ethics form amendments (section 3.10.), I was under the impression that this method may have prevented certain dynamics which characterise face-to-face interviews from surfacing. For instance, I considered physical proximity as a means for the participants and myself to build trust in each other. I*



*also wondered about the moments before the beginning of an interview and the preparation for it. I thought about the way the journey to the interview (such as taking the train), might prepare the interviewee and interviewer, for instance, wondering about the questions, and mindfully building towards the moment of meeting. In contrast, being at home doing things unrelated to the interview and suddenly feeling propelled in the interview via an electronic device, seemed like a different experience. I mused on the impact of using technology in this way on the process of extracting thoughts and emotions. I also considered that the automaticity of direct communication, and the opportunity to ask for clarification of a question's wording or, in the researcher's case prompting the interviewee to explore further, would still be granted. I also hoped that the flow of the natural conversation would not be lost.*

### **3.7. Data Collection**

#### *3.7.1. Research sample and selection criteria*

IPA's primary concern is to obtain detailed account of individual experience favouring quality over quantity (Smith et al., 2009). The IPA sample group is usually small and homogenous (Smith & Osborn, 2003), enabling a focused analysis on the proposed phenomenon of study. In accordance with the pillar of hermeneutics underpinning IPA, I embarked on an interpretational journey alongside the participants, and a small sample helped me in achieving this.

In accordance with IPA, purposive sampling was employed (Chapman & Smith, 2002). I decided to recruit a sample of eight English-speaking men over the age of eighteen. In accordance with Smith and Osborn's (2003) recommendations, eight participants seemed to be a suitable number to allow the generation of sufficient data from the interviews. To conduct IPA, the descriptions of participants' experiences must be rich (Willig, 2013) and interviewing men who did not feel confident speaking English might have led to a significant loss of data due to the language barrier. To ensure they could independently give their informed consent to take part in the study, I set a minimum age limit of eighteen years of age.

#### *3.7.2. Inclusion criteria and recruitment*

For the purpose of this study, participants had to report having had an experience of AN (appendix 7.1.). In order to address the wider concept of MoC across the journey of AN

(section 2.1. *Focus on motivation to change in this thesis*), volunteer participants' experiences of the ED needed include engagement with the recovery process. For this reason, the recruitment advert's top line stated 'Participants needed for research on men's experiences of recovering from Anorexia Nervosa' (appendix 7.2.).

ED sufferers may shift from one diagnosis to another and experience multiple EDs during their lives (Eddy et al., 2002). Experiencing or having had an experience of an additional MH issue was not therefore an exclusion criterion.

The principal exclusion criteria for taking part were a BMI lower than 17.5, which was assessed during the process of selection of participants, and not speaking the English language fluently. The former exclusion criterion was set for safety reasons in the interest of the well-being and potential vulnerability of participants.

Participants were recruited via poster advertisements at City, University of London, through UK-based charities' websites such as MGEDT and BEAT and Facebook (appendix 7.2). They were offered refund for the transportation costs up to £30.

Other researchers informed me about the difficulty in recruiting men who had an experience of AN. During the recruitment process, the majority of those who approached me were UK nationals currently living abroad or English-speaking men of other nationalities. I felt that opening the boundaries to outside of the UK would facilitate the recruitment process. Following a consultation with my supervisor, I requested to amend the recruitment criteria on the Ethics form and received approval (appendix 7.4.).

I selected participants in the chronological order of their enquiries to take part in the study. Communication with participants was initiated via email, however before each interview I spoke on the phone with each participant to go over the information sheet (appendix 7.5.) and to make sure they fulfilled the inclusion criteria and did not present with any of the exclusion criteria.

The ages of the participants were between twenty and forty-four.

Two out of eight of the men who took part in the research, reported considering themselves still experiencing 'AN related thoughts and behaviours' although their BMI was over 17.5. After thoughtful reflections and discussing opportunities with my supervisor, we decided to proceed in including them into the cohort.

I decided not to exclude these men from participating for the following reasons:

- a. They presented with the inclusion criteria and did not meet any of the exclusion criteria.
- b. Their wish to participate stemmed from their desire to tackle their issues which they admitted having neglected for some time. The interview would present a chance to face a part of their life which they wanted to readdress. I agreed with the participants, that our interview could have been a first preliminary step to a new phase in their journey towards recovery and change.
- c. Their level cognitive and social functioning was deemed enough for them to take part in a 60 minute interview on their experience of AN. This decision was made on the premises that they were both employed and working regularly, they were engaged in a consensual long-term romantic relationship and lived on their own.

Additional measures were put in place to ensure their safety: I agreed with them, they would inform their GP about taking part in the study. We also arranged to speak twice more before the interview to ensure their certainty of wanting to take part in the study. Moreover, we contracted to discuss the information sheet, consent form (appendix 7.6.) and debrief document's details (appendix 7.7.) during both phone calls. I offered to respond to any queries regarding their participation via email, on the phone, or in person should they have had any.

I anticipated that participants may have experienced strong emotions during or after the interview, therefore the debrief included contact details of ED organisations which offer support. This kind of support may have helped to address and process concerning thoughts and emotions which may have arisen during the interviews (appendix 7.7.).

Table I. shows the demographical details and additional information of the men who took part in this study. The data is based on participants' self-report and refer to the time of the interview. Pseudonyms were randomly assigned by myself and used for confidentiality purposes.

*Table I. – Participants' Demographical Details and other Information*

Name, Age, Nationality, Marital status, Age of Onset of AN, AN experienced in adulthood, In employment, Self-reported current phase of their journey with AN.

Name	Age	Nationality	Marital s.	Onset	Adulthood	Employed	Currently
------	-----	-------------	------------	-------	-----------	----------	-----------

Daniel	35	USA	Married	Late teens	Yes	Yes	Recovered
Edward	28	UK	In a relationship	Early 20s	Yes	Yes	Recovered
Liam	26	British	In a relationship	Early 20s	Yes	Yes	Struggling with motivation to recover
Nick	32	British	Single	Late teens	Yes	Yes	In recovery
Oscar	44	Italian	Married with children	Teens	Yes	Yes	Recovered
Matt	20	British	In a relationship	Teens	Yes	Yes	Struggling with motivation to recover
Wes	23	Canadian	Single	Late teens	Yes	Full-time education	In recovery
William	23	British	Single	Teens	No	Yes	Recovered

### 3.8. Procedure

#### 3.8.1. Rationale for using semi-structured interviews

Burgess (1984) defined qualitative interviews as “conversations with a purpose”. They are a means to “construct or reconstruct knowledge” (Mason, 2018, p.110) and are the most frequently used method in IPA (Willig, 2008). In accordance with IPA recommendations, data was collected through semi-structured interviews either face-to-face or using Skype video calls. The informal style and flexibility of this form of dialogue enables smoothness in the interaction between researcher and participant. Moreover, this arrangement can encourage spontaneity and the unearthing and subsequent elaboration of unexpected areas, which may shed light on new themes (Kvale, 1996). Despite the existence of other efficacious means of collecting verbal accounts, such as diaries, or telephone interviews, I felt that with a “fluid” (Mason, 2018), face-to-face dialogue I could capture concepts which depart from and deepen the interview schedule. Furthermore, by attending to facial

expression and tone of voice, I could monitor the general state of the participant and supplement my data collection, which may provide scope for additional exploration and ultimately enhance the quality of interpretations. In accordance with my epistemological stance, I believe that each interview will offer a “construction or reconstruction” (Mason, 2018) of the lived experience. There is no intention to generalise but rather to throw light on each account. Mason (2002, ch. 4) contended that it is “inappropriate to view these interactions as bias”. The reason is that we cannot discern the result of the interaction from the interaction itself, as the context is part of the outcome.

### *Individual interviews versus focus groups*

Consistent with the idiographic characteristics which lie at the heart of IPA, I chose individual interviews as a method of data collection. Individual interviews permit undivided attention of the researcher on the participant’s account and present with less interferences to the voice of the contributor, allowing a thorough unfolding of the story. One of the core features of IPA is interpretation, which is informed by a double hermeneutic where the participant tries to understand his subjective reality, while the researcher attempts to make sense of the participant as well as the world of the participant (Smith & Eatough, 2007); individual interviews privilege this type of interpretation. Focus groups may be a way to access a larger quantity of participants and may yield insights that would not have risen without the group dynamic (Morgan, 1997). Moreover, when analysing a focus group transcript, one engages in what is called a ‘multiple hermeneutic’ (Tomkins & Eatough, 2010), where the researcher endeavours to appreciate the group members who, in turn, attempt to make sense of their experience as well as that of others. Although some accounts would not emerge without the group setting, I found individual interviewing more fitting for ethical reasons too: due to the potentially vulnerable nature of the population of participants, and the sensitive area of enquiry.

### *3.8.2. Interviewing process*

Interviews took place at City, University of London (sections 3.7.2. and 3.10 for pre- and post-interview process). I booked interview rooms in advance to ensure availability. Four interviews were conducted using Skype video calls. Participants were provided with the participant information sheet which they had already been given a copy of prior to our first meeting. They were invited to read and sign the consent form before the interview began. Participants interviewed via Skype returned their signed and scanned consent forms via email. At the end of the interviews, participants were given the debrief (appendix 7.7.).

### 3.8.3. Interview schedule

I designed the interview schedule so that both the participants and myself could ease in to the interview (see end of this section; appendix 7.8. for detailed interview schedule). The first of the six questions was more general allowing the participants take the lead and discuss what seemed the most resonant with their experience. I hoped to elicit accounts with varying levels of descriptive, evaluative, and analytic content to extract rich data (Braun & Clarke, 2013) and prepared the interview schedule according to Smith and colleagues' (2009) suggestions as follows. I prepared prompts and key words which I could resort to, to encourage the participants to expand further, or if I noticed that they needed clarification. Mindful of time constraints, prompts would have been convenient to reset the focus on the question's topic in case I would sense we had gone off track.

*I remember fearing that participants were going to perceive a power imbalance, perhaps expecting to be misunderstood or that they would not have the opportunity to speak about what was most pressing for them. I also wondered whether they might have believed that I was an "expert" in the field and perhaps considered me more as a therapist or doctor rather than an interested researcher. For these reasons, whilst remaining aware of my researcher role, I aimed to maintain a curious stance, to expand and deepen the enquiry empathically and authentically. During the interview, I remember having the urge to reframe or reiterate what the participants said. This was a way for me to check my understanding of their words. This process helped to trigger and maintain the double hermeneutic. As I sought to clarify and decipher my understandings of participants' experiences, they were simultaneously making sense of their experiences. Interpretation involves the researcher making sense of the participant making sense of their experience – i.e., a "double hermeneutic" (Smith et al., 2009).*

#### *Interview Schedule*

- We were talking about the aim of the research earlier, to explore the experience of males' motivation to change in anorexia nervosa, I was wondering whether we could use your decision to take part as a starting point today, i.e. what motivated you to participate in this study?
- Given your experience of AN and your decision to take part in this study, I'm wondering where you feel would be a good point to start and discuss motivation to change in your journey.

- Do you remember if there was something, someone that influenced your motivation at the beginning of your journey in AN?
- Can you remember whether people or the environment influenced your feelings towards your condition?
- Do you feel you made some changes?
- What supported you at this point of change?

#### *3.8.4. Interview recording and transcribing*

The interviews were recorded onto two dictaphones and immediately uploaded on a laptop using double password protected folders. I addressed participants with a pseudonym of their choice during the interviews for confidentiality purposes. After their interviews I randomly allocated different pseudonyms to all of them for the analysis and write-up of the thesis.

Each interview was followed by note-taking on the pace of the narrative, language, and non-verbal cues of participants. I recorded the challenges I had faced during the interviews and my impressions around my interaction with the participants. Although Smith and colleagues (2009) did not specifically mention documenting anything other than verbatim transcription of interviews, I felt that these notes would support me and complement the transcriptions to conduct the subsequent data analysis and discussion of results. Vicary, Young, and Hicks (2017) described how keeping a written log directly contributes to fulfilling validity criteria, such as commitment, rigour, and transparency. It also may trigger processes of “learning, interpretation and bracketing” (Vicary et al., 2017, p.550), which occur in parallel to, and supplement, the systematic interpretative efforts of the researcher. Therefore, hopefully keeping a regular log has helped me develop my critical standpoint.

*The transcribing process was an enjoyable part of the research it allowed me to re-establish a connection with the participants, their experiences and narratives.*

### **3.9. Analytic Strategy**

IPA’s analytic process does not require strict adherence to a protocol (Smith et al., 2009). Nevertheless, as a first-time qualitative researcher, I did not feel confident in taking creative detours, and following guidelines helped me feel more secure about the way I conducted this stage of research. Whilst choosing to follow Smith and colleagues’ (2009) recommendations closely, I found Gee’s (2011) reflections significant in informing my analytic strategy as she provides clear and applicable examples.

To begin, I transcribed each interview verbatim. I then created a four-columned table and placed the text of each transcript in the third column starting from the left-hand side. I used the column on the left-hand side of the transcript to number the rows of the interview so I could easily locate quotes directly in the transcript (see appendix 7.9.). As idiography is at the heart of IPA's ethos (Willig, 2013), I did not want to conduct analysis on multiple transcripts concurrently. With this in mind, and committing to an iterative and inductive practise, I thoroughly analysed individual interviews. With the data that emerged from each transcript, I subsequently undertook the process of analysing the data across participants. I carried out the following procedure for every individual interview, one at a time.

Smith and colleagues' (2009) guidelines comprise six steps:

*First step: Reading and re-reading*

I read each transcript two or three times and re-listened to the recorded interview.

*This first step helped me form a deeper connection with the data. As I read, I noted my thoughts including expectations of the participants' experiences, ambiguities, and my uncertainties around understanding their "life story" (Smith et al., 2009). At the end of this phase I re-read the notes I had made after the interview. I noted additional comments regarding my sense of the participant and of the relationship built between myself and the participant. I believe these considerations were fascinating in relation to the quality of the data yielded from each narrative and the way participants' life stories were told.*

*Second step: Initial noting*

Next, I began writing comments next to the transcript, in the table's right-hand side column. The aim of this phase is to write "comprehensive and detailed" notes on the data (Smith et al., 2009). To preserve an exploratory attitude, the process of extracting data was gradual and tentative (Smith et al., 2009). Following Smith et al.'s (2009) suggestions, descriptive annotations were written in normal font, linguistic and semantic comments in italic and more conceptual/psychological comments were underlined. I drew information from the notes I made after each interview to help me tune in to the written transcripts and bring the participants' narratives to life. These notes regarded non-verbal language, such as posture, gestures, facial expressions, and helped me in supplementing the descriptive comments. Metaphors and images illustrated by the participants helped me to generate linguistic and



conceptual considerations. These were formed through opening a “cautious dialogue with theory” (Larkin & Thompson, 2012), hence by drawing upon psychological notions relevant to the participants’ experiences. In the endeavour to attend to the participants’ subjective reality and maintain closeness with their accounts, I chose to focus on each aspect separately following the abovementioned order (i.e., a. descriptive, b. linguistic/semantic, c. conceptual/psychological). As my immersion within the participants’ individual experiences became more intense, I also wrote questions or doubts which surfaced. I finally read the transcripts and listened to each interview once more to identify whether I had missed out material and to gauge whether there were patterns in the transcripts (Larkin & Thompson, 2012).

*Despite coming from a contextual constructionist position where interpretations and knowledge account for the researcher’s influence, I endeavoured to be mindful of how some beliefs and feelings towards the material were generated and where they stemmed from. This was not an easy process and encompassed a relentless elaboration of thoughts identifying the different ways my beliefs, expectations, personal experiences, and knowledge informed the conceptual comments. I remember being swayed towards making sense of words and experiences of participants according to my personal experiences or my knowledge of something. I tried to be very watchful of this almost automatic reflex, account for it and document it during the analytical stage. I sometimes found that some passages could be commented on from a linguistic and conceptual point of view, and therefore made comments for each. I tried to be exhaustive in my annotations so that I could expand and bring the thoughts together at a later stage. As Gee (2011) explained “the blending will occur in the write up”. Moreover, I remember feeling apprehensive that perhaps not being a native English speaker I would miss important points within the transcripts. To prevent further anxiety, I asked a peer and a former external supervisor to read short excerpts of the transcripts and to note what they would have extracted. Besides reassuring me that I was making annotations, and extracting themes, similarly to the way a native speaker would, this process was interesting as it corroborated how much of our individual or unique personas we bring into the qualitative research analysis.*

### *Third step: Developing emergent themes*

Larkin and Thompson’s article (2012) helped me prepare for this stage of analysis. My interpretative comments reflected the incorporation of the participant’s understandings with mine. I organised my notes on the right-hand column by highlighting recurrent topics in the same colour (appendix 7.10.). Departing from my commentaries, I tried to represent the

essences of these with verbatim phrases of the participants, or images they had evoked, to stay as true as I could to their lived experiences and understandings. Smith (2009) described this stage as the result of the researcher and participant's "collaborative efforts". I noted the emergent themes chronologically in the left column, which encompassed descriptive, linguistic and conceptual/psychological features of the interviews.

*Aware that the hermeneutic circle was an integral part of my work, I still wanted to remain faithful to the participants' terminology and to their stories whilst developing emerging themes. As Gee (2011, p.18) described, "I began to feel positively disloyal"; I progressed through the first two steps and naturally developed new ideas, viewpoints, and considerations. Cognisant of these dynamics, I did not want to impose dogmas upon the idiosyncrasies of the individual experience. Therefore, whilst interpreting, I chose to use the language of participants where possible when developing emergent themes. Keeping the quality criteria in mind (Yardley, 2000), I intended to respect and protect the participants' experiences and their authenticity. I enjoyed the creative component of making sense of the participants' interpretations, delving into the data, and attributing meaning to phrases; nevertheless, apprehension and self-questioning about the capacity to remain true to them remained present throughout.*

#### *Fourth step: Searching for connections across emergent themes*

I printed and cut the emergent themes for each interview into strips (appendix 7.11.) and observed patterns across the themes: for instance, whether some related to each other, recurred, or were consequential to each other. Some appeared to encapsulate others, and were clustered together. Other themes seemed to be in contradiction and were placed at opposite poles on a spectrum. Some seemed to be chronologically connected, whilst others related to key life events and were linked by a common context or circumstance. I used the analytic strategies, such as abstraction, subsumption, contextualization, polarization, function and numeration (Smith et al., 2009). These strategies used to organise themes are not mutually exclusive (Smith et al., 2009); hence discarding and selecting themes was expected at this stage. Master themes and sub-themes began to tentatively materialise, however, were kept provisional at this stage. I used paper clips and clustered themes together (appendix 7.11.). I then created tables using Microsoft Word and connected each group of clustered themes within a separate table (appendix 7.12.).

*This process helped me remove myself slightly from the participants' accounts and to bring more of myself into the interpretation level of the analysis. I felt that this part of the analysis*

*called for an increased involvement of the researcher's interpretation of the data as well as encouraging a greater creative input.*

#### *Fifth step: Moving to the next case*

In keeping with IPA's commitment to idiography, the analysis process for each interview was conducted in its entirety before moving onto the following transcript. This practise underscored the distinctiveness of each narrative, and helped me to focus on individual participant data. This analysis process facilitated bracketing my thoughts regarding the content and processes of an interview.

*I felt that my prior knowledge, beliefs, and personal experiences of AN were being shifted by novel ideas and viewpoints as I progressed with the analysis. It seemed inevitable that my views would continuously develop as I moved from one interview to another. I tried to be mindful of how new information and concepts were informing my interpretation of the transcripts, and my own experiences. I kept a record of the way I chose to make sense of the data and how I generated emergent themes. This record included the way I selected, clustered, and discarded themes. I endeavoured to maintain an exploratory and curious mind throughout. This was an interesting challenge, as expectations seemed to tempt me, leading me to presume what the themes would be, and encouraging me to take shortcuts, which I managed to avoid.*

#### *Sixth step: Looking for patterns across cases*

This was the last stage of the analytical process. To observe patterns across cases, I printed the themes that had emerged from each participant's transcript and then cut them out in strips. I then laid them on a desk to identify any connections, recurrences, or conflicting information. I followed Smith's (2011) advice that in a sample of eight participants all should be represented in all master themes and at least half of them are represented with an extract of their interview for each sub-theme (appendix 7.13. for table of theme recurrences). I generated three master themes, one with four and two with three sub-themes respectively (section 4., Figure 1.).

*I found this step was very challenging and I felt it called for further responsibility and creativity. It was demanding to carefully select the themes at this stage. I wanted to honour the men's life stories whilst weaving a story which evoked and was representative of their shared experiences. I wanted to do justice to their journeys, to their honesty, and to their*

*commitment to the research.*

### **3.10. Ethics**

As a member of the British Psychology Society (BPS) and a future psychologist, ethical conduct is central to my work as a therapist and researcher. The Department of Psychology's Ethics committee of City, University of London granted approval for me to undertake this study (appendix 7.3.) Throughout the research process I abided by the British Psychological Society Code of Ethics and Conduct (2018), the British Psychological Society Code of Human Research Ethics (2014) and the HCPC Guidance on Conduct and Ethics for Students (2016).

The BPS Code of Ethics and Conduct (2018) centres on respect, competence, responsibility, and integrity, values which I incorporated throughout all stages of my research study. I believe that demonstrating respect invites the researcher to observe the other three values. The four values remained at the heart of all of my choices. During the research process I questioned the quality of my work by keeping a journal, using supervisory sessions, discussing issues with peers and colleagues regularly, reading widely, participating in an IPA forum, and attending an IPA group for researchers.

Whilst designing this study, I faced challenging decisions, such as creating the interview schedule and including or excluding certain potential participants. I dealt with delicate matters during data collection, such as monitoring the mental and emotional well-being of participants during and following their interview. Acknowledging potential emotional sensitivity, if the participant would have signalled distress or concern during the interview, I would have interrupted the interview and helped the participant to seek appropriate support. At the end of each interview, I provided contacts of organisations which the participants' may have found useful should they have required support after the interview (appendix 7.7.). Participants did not appear to be distressed during the interviews and did not signal uneasiness or a wish to interrupt the dialogue.

I informed two peers via text before the beginning of each face-to-face interview with details concerning start time, expected duration and location of the interview. I made sure I could prevent foreseeable physical and mental risks to the participants by conducting interviews on University grounds or on Skype. This was to safeguard myself and the interviewees and to ensure I would never be alone with participants as I was meeting them for the first time.

The measures I took to warrant my own safety and the participants' in compliance with the British Psychological Society Code of Human Research Ethics (2014) follow.

### *Participant Information Sheet*

The information sheet (appendix 7.5.) was emailed to each participant shortly after they had agreed to take part in the study. The same document was given to the men before the beginning of their interview. Mindful of wanting to prevent instances of potential deception, the document reminded participants of:

- a. The purpose of the study.
- b. The means of recruitment used.
- c. The selection criteria.
- d. What the participants could expect from taking part in the interview (including duration of the interview).
- e. the systems employed to store data generated during the interviews to ensure *confidentiality* of their personal details. Limitations to confidentiality were clearly outlined: should I have felt that their life was currently in danger, or someone else's life was at risk due to self-inflicted harm or harm from others, I would have discussed this with them and the research supervisor and may have had to report this to authorities.
- f. The subsequent stages of the research study, i.e., how their interviews would be used for this research.
- g. The use of a pseudonym to *protect* their *anonymity*.
- h. The foreseeable risks and advantages of taking part in the study. For instance, participants' sensitivity to certain topics or feelings difficult to manage.
- i. The ways to *withdraw* from taking part in the research were made explicit and provided option to withdraw until three months after the interview. Participants were reminded that they did not have to provide any explanation to withdraw, nor would they incur any penalty.

### *Consent form*

Participants received the consent form via email (appendix 7.6.) prior to their interview. Signed consent was obtained from each participant before the interview after having read the information sheet. If the interviews were conducted on Skype, participants signed, scanned and emailed their consent form.

### *Debrief*

After every interview, I read the debrief document (appendix 7.7.) aloud and emailed the document to each participant. I enquired whether all points were clear and invited participants to get in touch should they have wished to address anything discussed in the interview further, or if they needed assistance in finding help. Two participants emailed me shortly after the interview to tell me the interview had stirred some thoughts and had drawn them closer to their families. They both described considering returning to therapy. I listened to their words and signposted them to their GPs and to organisations which assist people living with EDs in finding psychological support.

### *Ethics form's amendments*

Given the difficulty in recruiting men who had an experience of AN and to some of the volunteer participants residing abroad, together with my supervisor, I considered expanding the catchment area of recruitment using a dedicated Facebook page. Moreover, during the recruitment and data collection phase a close family member had unexpected severe health issues which I had to attend to, causing me to spend extended periods of time abroad. I applied for amendments to the original ethics form and also requested the possibility of carrying out interviews remotely (via Skype video calls) as I would have not conducted all interviews in person. These changes were approved (appendix 7.4.).

## **3.11. Validity and Reliability**

### *3.11.1. Validity*

As a CP in training I value the unique experiences of individuals. In my clinical practice, I strive to tailor therapy and treatment models according to the needs and wishes of clients. In parallel, as a researcher, with this study I proposed to give voice to individual participants, highlighting the divergences in experiences whilst stressing the common characteristics. Qualitative research methods do not have “universally agreed criteria” (Yardley, 2000) to assess quality of the research and are criticised for their potential bias and subjective nature. Finlay (2002, p.212) proposed that qualitative research produces “co-constituted” knowledge generated from the researcher and interviewee’s interaction. Given that I have had an active function during all stages of the research, I have aimed to evaluate this study in accordance with my epistemological position. As Finlay (2002, p.212) suggested, “through the use of reflexivity[...]subjectivity can be transformed from problem to opportunity”. Qualitative data

should be evaluated in relation to criteria which are deemed adequate (Smith et al., 2009); reliability and validity are appropriate to assess quantitative data. Validity plays a different role within qualitative research, and specifically in the phenomenological approach (Giorgi, 2002). Yardley's (2000) criteria can be applied to all qualitative research (Smith et al., 2009). Aware of the ongoing dilemmas around evaluation and compliance with validity criteria in qualitative research, I chose to follow Yardley's (2000) guidelines, comprised of four criteria, to conduct this study and to appraise the quality of this research.

### *3.11.2. Sensitivity to the context*

For Yardley (2000) sensitivity to the context involves evaluating existing literature which has addressed similar topics and employed the same methods of enquiry. Within the Introduction, the literature review section critically addressed past studies on MoC within EDs and the studies regarding men who experienced EDs, more specifically AN and commented on those enquiries which employed IPA. Sensitivity to context also means being aware of the socio-cultural environment in which the research is conducted. In consideration of this criterion, reflexivity sections throughout this thesis echo my thoughts, beliefs, expectations in consideration of the language used during the interviews, the cultures involved (mine and the participants'), the society at large and its involvement in the treatment of men with EDs, and the interactions between myself and the participants.

### *3.11.3. Commitment and rigour*

Commitment and rigour are criteria which directly relate to the researcher's relationship with the studied topic. This topic is very connected to me as I personally experienced AN, and have experienced this MH difficulty indirectly as a friend and practitioner. My commitment to this topic has been constant since prior to embarking on my doctoral training in CP. This entailed reading biographies of sufferers, carers and relatives of people who suffered with AN. I attended conferences focusing on men's experiences of EDs, and relevant research modules at university, and also had regular research supervision. I joined an IPA peer support group and an online forum to cultivate inspiration, improve my research skills, gain feedback and challenge my understandings. Smith and colleagues (2009) stated that commitment should also be present with regards to the participants. In keeping with IPA, I endeavoured to stay true to the participant's words wherever possible. Furthermore, when reporting the results, I provided quotes and examples from the transcripts to best convey the experiences of the participants. This fostered my commitment to ensuring the closeness of the analysis's to the data.

Rigour is related to thoroughness of data collection and depth and breadth of the analysis (Yardley, 2000). In accordance with IPA, the aim of this study was to focus on the idiographic value of the participants' experiences, rather than generalisability. Therefore, the sample size did not have to be representative of the population under study. Instead, this research regarded collecting data from a homogenous sample as important. The analytic procedure of IPA is systematic in nature and aims to obtain detailed descriptions through the analysis of the data (Willig, 2008). To ensure depth of the analysis, and in line with the research approach, I was committed to going beyond the data's descriptive level and adopting an interpretative stance. I employed "triangulation" (Yardley, 2000) in several stages of my research by asking my supervisor to assess the pertinence of the interview schedule to the IPA ethos, and thus to the research question. I invited peers and supervisors to share their understanding and interpretation of anonymised interview excerpts. I kept records of my thoughts, challenges, and efforts regarding the study throughout the whole research process. I also kept a personal log to trace my beliefs, understandings and relationship with the project throughout the research journey. These passages helped me to deepen and extend the breadth of my reflexivity during the analytical process. They also helped me to take a step back from the immersion in the data, therefore enhancing the quality of the study.

#### *3.11.4. Coherence and transparency*

Coherence relates to the consistency between the research question, the philosophical underpinnings of the research project and the method adopted. Transparency relates to the presentation of the data collection and the analysis. I tried honour transparency and coherence by documenting every step of the data collection and data analysis. I have included excerpts of the transcripts and of the various stages of the analysis (appendices 7.9.-7.12.). As mentioned earlier, IPA values the idiosyncrasies of the participants' experiences and adopts an interpretative stance in the analysis stage to shed light on the data collected. I endeavoured to ensure transparency during the research process by assiduously engaging with reflexivity. I hope this emerges in the sections in italic throughout this thesis.

#### *3.11.5. Impact and importance*



With this study, my aim is to meaningfully contribute to the existing body of research in psychology. Impact and importance have been addressed in the Introduction and Discussion chapters of the thesis respectively (sections 2.1., 2.4.3, 5.6.).

In addition, Parker (2004) suggested three overarching criteria for good qualitative research, and he invited the researcher to consider these with flexibility and to challenge them depending on the characteristics of the research project. The first one is “grounding” the study within the existing body of literature in order to recognize gaps in past research and develop new research questions. The second criterion is “coherence” of the arguments in terms of the narrative which results from the data analysis. The third criterion relates to the “accessibility” of the presentation. This means providing a clear production of the background information, of the “research process” and of the interpretations and of the newly developed knowledge. I kept Parker’s (2004) criteria in my mind during all stages of this research study.

#### *3.11.6. Criteria specific to IPA*

According to Smith (2011) an IPA paper is deemed “acceptable” when it meets the following four criteria: 1. It clearly subscribes to the theoretical principles of IPA: phenomenological, hermeneutic and idiographic, 2. it is sufficiently transparent for the reader to understand what was done, 3. the analysis is coherent, plausible and interesting, and 4. that there is sufficient sampling from the participants to provide evidence for the themes, i.e. for a study with eight participants, three or more extracts per sub-theme.

For a paper to be considered “good”, Smith (2011) recommended additional criteria: 1. that the research is well-focused and that the analysis offers depth of the topic, 2. that there is richness in the data and that the interpretation is strong, and 3. that this is interesting and informative for the reader.

To ensure the above-mentioned criteria, throughout the analysis and discussion of results processes, parts of the analysis and sections from the discussion were evaluated with, two peers at university, my research supervisor and with a qualified CP to note whether they made sense, demonstrated integrity, and vividness of the participants’ experiences.

#### *3.11.7. Generalisability*

Quantitative researchers strive towards generalisability of their results. IPA is based on the principles of phenomenology and idiography and by nature is not based on assumptions, nor does it hope to confirm or disconfirm these. IPA's purpose is to appreciate meanings of people's experiences. Whereas positivists are concerned with statistical generalisation of their findings, Johnson (1997) explained that qualitative researchers hope that their understandings may be applicable in other related situations. This means that outcomes can be 'transferred' and may be pertinent to other individuals too (Finlay & Steward, 2006). Again, qualitative research demonstrates its flexibility: while contexts may show similarities, they still maintain other, very different features (Yardley, 2000). It is my hope that the findings from this research may be transferable to a wider sample, in devising future research projects and in clinical practice for CPs.

### **3.12. Reflexivity**

Reflexivity is the researcher's process of "continually reflecting upon interpretations of both his or her own experiences and the phenomenon being studied", attempting to move beyond preconceptions (Finlay, 2003, p.108). Reflexivity involves identifying the experiences, whilst separating them from the actual phenomenon, and simultaneously observing the interpretations we make and how these dictate the course of the study. Critics routinely dismiss reflexivity as "bias" (Finlay, 2002), however for Frank (1997, p.89), "the challenge is not to eliminate 'bias' to be more neutral, but to use it as a focus for more intense insight" without it becoming too self-involving.

As a future CP, reflexivity has been an integral part of my training. I feel that reflexivity is organic to the way I make sense of and go about my personal thoughts, judgments, assumptions and relationships in the world.

Reflexivity has been an essential feature of this study from its early stages. Moreover, as Willig (2013, p. 96) maintained, the "researcher's understanding of participants' thoughts is influenced by his or her way of thinking, assumptions and conceptions". In line with the interpretative phenomenological underpinnings of this study, these are not to be 'reduced' in the attempt to avoid 'adulteration' of the participants' accounts. Instead, these are indispensable for interpretation; they inherently enrich the accounts. The outcome is also considered to be reflexive, because it is informed and substantiated by the "researcher's own standpoint" (Willig, 2013, p. 96).

#### *3.12.1. Methodological reflexivity*

*In line with Finlay's (2002) acknowledgement of reflexivity as a standard for quality and of Yardley's (2000) quality and validity criteria mentioned above, with this section, I aimed to openly reflect on the impact which I may have had on the methodology of this research study. As Willig (2008) proposed, shedding light on this will enhance a study's rigour. Given that the wealth of literature on EDs and AN seems to focus predominantly on women, one of my pre-assumptions was that men's experiences of AN were going to show divergent or singular characteristics in comparison to those reported in females. Another sense I had, given the articles I had read, was that men with AN might not be interested in becoming thin, but rather developing a muscular figure (Griffiths et al., 2013) I also thought that it might be likely that the men I would interview may have felt stigmatised due to their experience of AN (Soban, 2006; Petrie & McFarland, 2009).*

*However, as a future CP, I wanted to remain curious and open to participants' experiences. I wanted to immerse myself in their narratives, and was fearful of contaminating our interaction, and the understandings which would ensue, with my pre-assumptions. Prior to writing the interview schedule and before the interviewing stage, I discussed my preconceptions and beliefs with peers and with my research supervisor. I also set time aside regularly to expand upon these emerging beliefs. These reflexive exercises helped me recognise the ways I approached researching the literature and selecting topics of interest. Reflexivity assisted me in evaluating the first draft of my interview schedule which seemed tainted by my pre-assumptions. For instance, it seemed that 'change' meant a shift towards recovery. I subsequently amended the questions making them more neutral and accessible for participants who may not have shared my pre-conceptions. I wanted to infuse empathy and avoid making participants feel a need to respond within or from a certain frame.*

*Methodological reflections also emerge in my decision to employ a qualitative paradigm for this research and also in my epistemological and ontological position (section 3.4.) Personal and methodological reflections, can be found throughout this thesis in italic, as I sought to remain aware of and transparent about the procedures underlying all decision-making.*

### *3.12.2. Personal reflexivity*

The phenomenological researcher is expected to have an approach characterised by "openness and wonder" (Finlay, 2002, p.536). Reflexivity, is an instrument which promotes the researcher's awareness in the process of enquiry, and is a means of keeping track of his

or her involvement. As Finlay (2002, p.537) contended “only by bringing our implicit frameworks into relief do we stand a chance of becoming relatively independent of them”.

*I chose to explore the experiences of change within the journey with AN also because I experienced AN during my twenties. My experience could have been described as me having a strong anorexic mind which seemed not to match my bodily appearance. Although I lost a significant amount of weight in a short period of time and became very thin, my own weight loss was never enough to be hospitalised. Nevertheless, the extended time of being underweight has caused severe and irreversible damage to my health.*

*I am a woman and my AN was immediately acknowledged and in some way “accepted” (perhaps because of my gender) by family and friends. Although I was supported and helped, in some regards I felt that the gravity of the issue was overlooked, perhaps because it was not a ‘by the book’ manifestation. Unfortunately, this facilitated concealing behaviours and deceiving others and myself further. These circumstances were detrimental to my mental and physical health and contributed to the deeper rooting of AN.*

*For multiple reasons, previously discussed (section 2.1.), too often men’s experiences of EDs are not seen, addressed or taken as seriously as they should be. Resonating with my own experience, possibly men are alone in their uneasiness and distress, and left to make important and challenging shifts towards recovery on their own. Exploring and capturing emotions, thoughts, and the circumstances sufferers can associate with motivation can be very interesting and valuable in helping others during their experience of AN. Moreover, developing a deeper insight into sufferers’ experiences can assist families, carers, and professionals improve their understanding of what can be beneficial in fostering the sufferers’ MoC.*

*Upon embarking on the doctoral journey, I remember feeling slightly apprehensive about working with the AN population. I felt that, perhaps bearing witness to the self-destruction, which I had experienced myself, would have been a challenge, leaving me feeling unequipped to offer my professional support. With the help of personal psychological therapy, keeping a regular journal, and the passage of time, I felt competent and confident working with clients with an experience of AN. The principles of person-centred therapy served as a bedrock for me to build rapport with all of my clients regardless of the therapeutic approach.*

*Carrying out qualitative research, and specifically IPA, demands that the researcher become an active constituent of the study. Through my pre-understandings and my experiences, I lead the course of the study, becoming a subject in the process (Finlay, 2008). Furthermore, as Cooley (1902) describes the “looking glass self”, ‘I’ am the object: I mirror and observe myself in the reactions of the participants, and, for these reasons, pre-judgments and understandings must be accounted for.*

*I endeavoured to gain a balance between drawing out relevant material and being overly-self-protective (Finlay, 2002). I kept a regular journal and used personal therapy as well as supervision sessions to observe and consider the ways that I was bringing myself into the study. Looking back on this path I noticed how much I have changed internally, and changed in regard to my views on AN. I noticed that the most difficult and perhaps painful part of writing this thesis was the Introduction. Reading and writing about the long-term effects of AN allowed my own anxieties and grief to resurface. I was aware of the long-term consequences of AN, yet the exposure to the information and the process of reframing and writing, did not let me shy away from them.*

#### 4. Chapter Three: Analysis

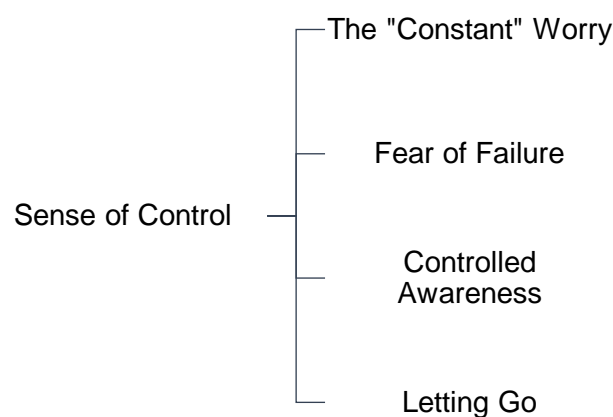
This research seeks to focus on MoC in relation to men's journeys of AN. To make sense of participants' narratives and to identify nuances and idiosyncrasies within the cohort, it was important to reflect on how motivation manifested in relation to various aspects within their journey with AN. Therefore, this study does not want to solely attend to MoC in relation to recovery from the illness. This approach will hopefully act as an invitation for professionals and researchers, to adopt a holistic perspective with regards to male experiences which to date seem to be underexplored. Through the participants' recollections of MoC, their drivers, cautions, and resistances within the AN experience emerge.

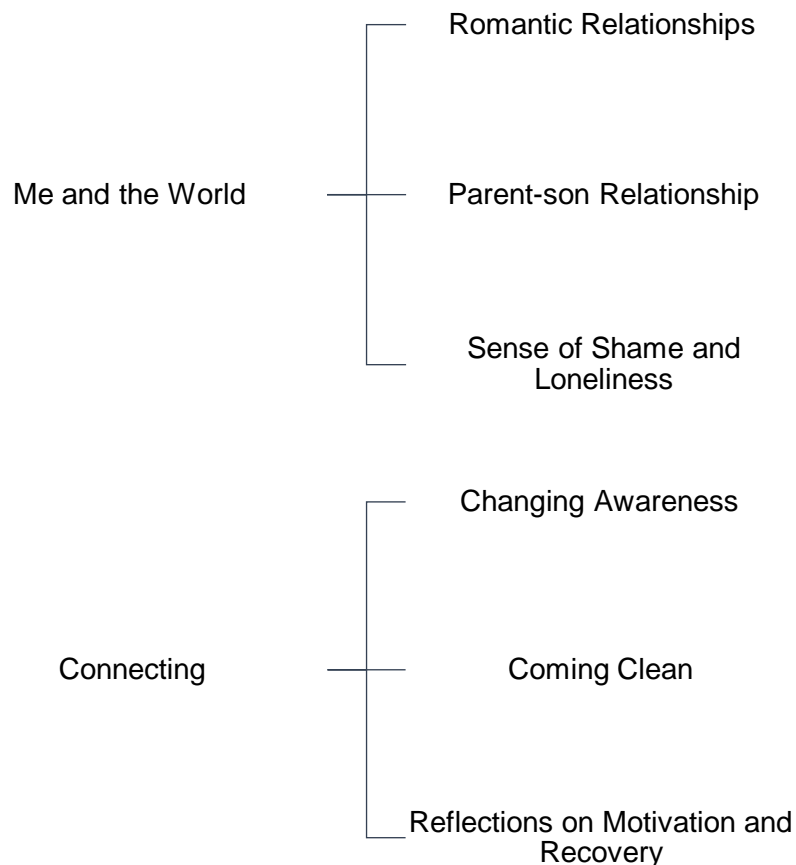
This chapter aims to present a detailed and systematic overview of the participants' interpretations of their lived experiences in relation to their AN (Smith et al., 2009).

To "give voice" to participants and "make sense and contextualise their claims" (Larkin et al., 2006, p. 102), interpretation is essential as results are a "co-construction between participant and analyst" (Osborn & Smith, 1998, p. 67). However, at this stage, as Smith and colleagues (2009) recommended, to get as close as possible to their lived experiences, and to see the world through their lens, there is no effort to link research evidence to their experiences.

Within the block quotations reporting participants' statements, segments that did not seem directly pertinent to the topic being analysed, have been taken out and noted by three dots within squared brackets.

*Figure 1. Outline of the Master Themes and the Sub-themes*





#### **4.1. Master theme I: Sense of Control**

This theme explores the participants' experiences of their need to control certain areas of their life during AN. Sense of control seemed to emerge for all participants. It was also reflected in their language, and in the way some structured their responses to questions. Sense of control seemed to manifest both as a goal to achieve and as a torment throughout their journeys. The sub-themes aim to show how the theme was represented, understood and experienced by the participants.

##### ***4.1.1. The "constant" worry***

All participants seemed to share a sense of long-lasting worry towards many areas of their life including, food intake, weight, planning time and sense of feeling "productive".

William explained that his constant worry led his journey with the ED, and how this manifested in his food intake:

I worried a lot and, I still worry a lot about different things, that's kind of part of my personality but there, I'd worry constantly particularly about what I was eating and if I ate eh say a bit more...then I'd panic and become obsessive about it[...] 'cause I've eaten a bit more for this dinner tomorrow night I'm gonna eat much less just to make up for it. (William: 207-217)

*As William spoke, I felt tension, and the sensation of a knot in my throat at his idea of possibly never being able to relax and not being able to forgive himself.*

William explained how his worry manifested as he endeavoured to feel productive:

by doing that it gave me something to do, I've always been quite a kind of perfectionist and sort of obsessive about planning[...]there's some underlying eh obsession with control and doing something uhm to make the day seem more productive. (William: 162-171)

Participants experiences of worry often appeared to intensify and turn into "obsession", a term also used by other participants. For example, Daniel said:

I actually became addicted and obsessed with scales (Daniel: 432-433)

I would go to run obsessively (Daniel: 438)

"Obsession" is defined as "an idea or thought that continually preoccupies or intrudes on a person's mind" (Oxford English Dictionary, 2017). The term does not imply a voluntary and conscious thought directed towards something, where the individual endeavours towards achieving a goal.

*I wonder whether "obsession" may be conceptualised here as the thought taking power over the individual? This might be an interesting reflection when considering Matt's experience of unrelenting worry.*

for me it's been literally every minute of every day, if I haven't behaved, this set of rules, which may be completely insane to some, like starve yourself for a day, or throwing up whatever you've eaten, over-exercise to avoid going through all that, and the stress caused by it, you just have to obey these rules. (Matt: 220-224)



It is interesting to note Matt's description of his ritualistic behaviours: "set of rules[...]obey these rules", which might indicate the conflict experienced as he felt both, a master and a servant:

I'm in control; I'm also completely a slave (Matt: 525)

*I wondered how the 'involuntary' obsession reconciles with the deliberate perfectionistic endeavours (p. 81, William: 162-171).*

Nick recollected his unceasing worry by evoking his sense of control and energy consumption:

so much of my energy is taken up with thinking about food and thinking about my weight and thinking about am I walking too much, or am I walking enough[...]The diet I'm on, and that was sort of ten times worse when I was really ill eh[...]and it just leaves you no space to think or do anything else and it's really really dull. And, yeah realising that helped me change. (Nick: 364-376)

The way Nick repeated the term "thinking" linked to "energy" seemed to suggest that his experience of AN was both physically and cognitively demanding, impacting his activity in terms of what he could do. His experience of unrelenting worry appeared to allow him to consider change.

*The rhythm of Nick's narrative and his tone of voice seemed to convey a sense of frustration towards his worry, which limited his existence. As I connected to Nick's words and his use of negative statements, "I just can't[...]I couldn't cope[...]irritating[...]energy taken up[...]ten times worse[...]no space[...]really really dull", I remember feeling a sense of exhaustion and entrapment.*

Edward explained his worry manifested in his relationship with time:

always time is a big concern for me[...]but I think in terms of not wasting time as well[...] It's a hard one to balance still I still struggle with that because you want to have time off[...]but being less busy job-wise is something that I'm scared of. (Edward: 73-80)

Edward's description seemed to indicate that his worry regarding time and its allocation was continuous and pervasive as it affected his everyday life; having a controlled busy schedule appeared to shield him against his fear of having spare time.

#### *4.1.2. Fear of failure*

This theme appeared to be a sentiment common to all participants. With regards to fear of failure (Ff), some statements seemed to be describing avoiding failure others striving for success. The interviews revealed the different beliefs associated with Ff, achievement and motivation for participants. Although Ff was ubiquitous, specific beliefs around the consequences of failure varied across participants. Therefore, their experiences reflected the different ways they engaged with the feeling.

For Nick, his journey with AN was characterised by the “pressure[...]to succeed” at keeping in control (245), and he also recognised this attitude in other sufferers of AN. Interestingly, Nick revealed that his pressure to succeed at keeping the AN active and in control, then shifted into fearing an unsuccessful recovery process. He added that he feared to “be seen to fail” (413).

I sort of felt quite a lot of pressure that I have to succeed at it, and I think a lot of anorexics, are quite perfectionists and I'm quite driven[...]not recovering, not being seen to recover would be worse than getting this in the first place. So there's that sort of fear, has driven me at times...Yeah. (Nick: 245-254)

once I got in the position of being more open to people that I had a problem and I was trying to recover, then I had to not be seen to fail (Nick: 411-413)

Nick's statement might have suggested that part of his MoC, and how he channelled his determination towards recovery, was fuelled by other people's opinion of him.

*I remember asking myself whether Nick was waiting for me to concur with his statements. For instance, when he expressed his opinion regarding other people who experienced AN being “perfectionists”. Nick's tentative language in this passage, “I sort of felt quite a lot of pressure[...]I think a lot of[...]quite perfectionists[...]I'm quite driven[...]” might have reflected his uneasiness in making a bolder statement and preoccupation with my view. I wondered whether this might have been a manifestation of his Ff.*

Similarly to Nick, whilst speaking about his journey, Wes remembered a thought which seemed to be signalling a demanding self:

Am I even going to be good at recovery? (Wes: 273-274)

It looked like Nick and Wes's determination to succeed and not to be "seen to fail" took priority over the end goals they set for themselves. The sense of success appeared as paramount, and their Ff seemed to drive them to engage in different kinds of behaviours.

Matt, too told me he struggled with the "fear of failure" (204). He admitted using physical exercise to try to avoid that feeling. His Ff also became apparent when describing how he became more and more inflexible in his daily routines and targets by decreasing his food intake and pushing himself to achieve unhealthy goals:

the anxiety is there and you've, it's a sense of failure so to avoid that, every single behaviour to do with anorexia or bulimia I found over-exercising is just try- fight-, trying to avoid the anxiety, and the feeling of failure so, so in a way the bar would get lower[...]it's just control. (Matt: 204-216)

"Every single behaviour" signalled the pervasiveness of the Ff within his life. The "sense of failure" which Matt seemed to experience resulted in "anxiety". Matt described feeling motivated to avoid the "anxiety" and did this by engaging in demanding behaviours.

*A written transcript might not render justice to the unaltered rhythm and volume, and monotonous tone of voice in Matt's narrative. These qualities of his account are interesting when reflecting on his experience of relentless sense of control. I often, myself, felt confined and stuck in his narrative, I felt like a hostage almost as if his account reflected the intensity of his control. I wondered about the function of the last three words, "it's just control". Was Matt trying to reassure and encourage himself, that it was just routine (a mechanism which was known to him and with which he was familiar)? Or was he talking to me, trying to clarify that it was all down to control?*

*When Matt referred to the bar getting lower and trying to reach a new target, I associated this act with the pursuit of feelings of self-worth and positive regard. I wondered whether aiming to achieve a new target when the "bar would get lower" was tapping into Matt's self-esteem. Was achieving the new targets (and avoiding the sense of failure) offering him an immediate comfort? Should this have been the case, it seemed that the comforting feeling*

*had limited lasting effects: in fact, in Matt's description there is no mention of "maximum limit" or "threshold" to "the bar getting lower". This may have implied that in Matt's endeavour to achieve goals, the "lowering of the bar" in order to avoid a sense of failure, was continuous with no sense of boundary.*

Like Matt, Liam too engaged in an avoidance behaviour, which seemed to be driven by a Ff. Liam however, seemed in search of "success" or "victory" within his quest to keep his body weight under control:

I've been spending all this effort on trying not to put on weight or lose weight but I've got no way of measuring if that's successful or not so it's, there's no, there's no victory there's no end point, it's do you know what I mean? (Liam: 724-731)

Liam admitted never checking his body weight on a scale, possibly to avoid the truth. In his journey with AN, avoidance emerged as a recurring theme. There being "no end point" meant that Liam could not possibly verify his success or failure in controlling weight. By avoiding stepping on the scale, he seemed to actively choose not to measure the effects of his efforts. Liam mentioned other areas of his life which he valued, and believed that he was managing to be successful at these:

I mean it's definitely, I've definitely learnt to cope with well- no, I don't know, that's- I definitely see that I've learned to cope with things. I am reasonably successful with work, I'm doing okay kind of socially, stuff like (Liam: 441-442)

"Definitely" is an emphatic word which involves certainty and finality (Oxford English Dictionary, 2017) The recurrent use of the term "definitely", echoed like an indisputable mantra which seemed to have a double function: 1. to convince me, the researcher, that he was determined to succeed in other areas of his life despite the admitted difficulties with the ED, therefore not being a failure. 2. as a self-convincing tool. Repeating it with insistence almost excluded any possibility to question otherwise. However this is in contrast with some hesitation in his words when expressing "well-no[...]okay kind of[...]".

*I remember wondering whether the other areas at which Liam felt successful helped and supported him in shifting his attention from his body weight.*

William's susceptibility to the anticipation of an experience of failure seemed to be activated by his anxiety of feeling embarrassed.

Because the embarrassment I felt was so strong that I would have never told anyone, and would have never even contemplated them helping me because I never would've told them and they never would've known[...]I didn't want any help uhm, plus it goes along, with the kind of, want of a sense of control in that I want to get out of it myself and I and my stubbornness in that I absolutely didn't want to tell anyone. (William: 821-834)

William's determination to retain autonomy and exert control in concealing his eating difficulties was fuelled by the power of his fear. This prevented him from reaching out to ask for help. The repetition of "never", "any help" and "anyone" highlighted William's determination for independence. Moreover, his underlying anxiety regarding failing seemed to surface through his drive towards efficiency and his unceasing battle with wasting time. This seemed to be evidenced in the structure of his responses during the interview and the terms he chose. It sometimes looked like he wanted to control the interview. For instance:

Yeah, can you ask me another question? (William: 429-430)

uhm yeah. Ask me something else! (William: 570-571)

So what was your question, I forgot. It was- I've completely gone off. (William: 690-691)

I had the sense that he availed himself of these phrases when he ran out of the things he wanted to say. The passages above might suggest a fear of not doing well enough in the interview, or anxiety of not completing a task as expected.

It is fascinating to note the value that some participants attributed to Ff and the weight it bore on their existence. It looked like they were on a mission, willing to sacrifice many areas of their life to avoid failure or to pursue success.

*I wondered what the participants did not want to confront, perhaps the underlying feelings which a sense of failure would elicit. I also considered sense of failure as an emotion which perhaps they did not know how to manage; maybe they had not learned how to sit with it? To deepen my understanding of the experiences they were disclosing, I attempted to feel the sense of failure which they described they were escaping from. I remember trying to attune to my own everyday life experiences and how I made sense of these in relation to what*

*being successful or a failure was for me. I noticed how my thoughts and feelings had changed in recent years. I noted what encounters and experiences had assisted me in this change. Perhaps the participants' paths through their sense of Ff is an important piece of their life journey, and through their experiences of it they are informing parts of their sense of selves.*

#### 4.1.3. Controlled awareness

During their journey with AN, participants appeared to work hard to control various areas of their lives. It looked like participants were aware of what was going on for them, including the severity and the repercussions of AN on their mental and physical health. However, for part of their journey with AN, their minds seemed impermeable to this awareness. Interestingly, their awareness around their experience of the illness, including their thoughts, emotions, and physical conditions, seemed to be regulated and controlled for it not to interfere with their quest to control their body weight and appearance.

*I noticed the way I conceptualised participants' management of their awareness in categories which seemed to resemble a cognitive behavioural conceptualisation: affect and bodily sensations, behaviours, and thoughts. Perhaps due to my training on the doctoral programme, the 'cognitive behavioural logic' appeared relevant to me whilst seeking to make sense of awareness. Perhaps this issue revealed my own desire to assert some control.*

Edward described his physical sensations when restricting his food intake, demonstrating awareness of his felt sense, and the effect this had on his psychological state:

The sort of feeling of being absolutely famished and hollow and enjoying that; revelling. (Edward: 460-462)

When I was restricting I felt very light, and by light I mean physical and mental. So, I was kind of a bag blowing in the breeze (Edward: 788-791)

Edward cherished feelings of bodily emptiness, starvation, and lightness. This quote is an interesting juxtaposition to Edward's pursuit to fill in vacant moments in time, as explored earlier (p. 83, Edward: 73-80).

Whilst William appeared to understand the severity of his AN as a MH condition, his awareness did not penetrate the control over his every day routine.

I'd heard a lot about how[...]uhm, how mental illnesses like eating disorders can become a way of controlling your life, or providing a sense of stability, and so I think that might've played into it[...]uhm, by doing that it gave me something to do  
(William: 152-166)

Rather than being concerned about the repercussions on his health, it looked like William allowed AN to control his life enabling him to meet his need to fill time.

Matt seemed to acknowledge his awareness of how the ED was affecting him:

that's as serious, and for those living it uhm, it's very lethal, of course it is! It's very lethal and that deserves as much attention and research and people to take it seriously as a physical, you know serious physical illnesses or other more, shall we say well known like mental, mental health issues like to be regarded, taking seriously  
(Matt: 34-39)

Matt appeared to be keen to convey the seriousness of AN and its repercussions on physical and MH aspects of the experience.

*Through the repetition of terms "lethal" and "serious", Matt seemed to want to caution others of the repercussions that AN may carry. Perhaps Matt's experience led him to believe that the external world does not take AN as seriously as it should? I wondered whether his apparent awareness of the illness's risks would eventually motivate him towards change, or if similarly to William, his need to exert control would act on his awareness, advantaging AN.*

On a cognitive level, participants seemed to be aware of their physical health and appearance and, to a degree, AN's implications for their health.

so it's constantly there's new incentives every day to keep starving myself (Matt: 701-702)

If I look like a skeleton then you'll love me, then you'll take care of me if I look ill. It was very very twisted (Wes: 750-752)

As noted above, levels and impact of awareness around AN seemed to change over time and from person to person (see *Changing awareness*, section 4.3.1.).

#### 4.1.4. *Letting go*

'Letting go' was understood as "the relinquishment of someone's hold onto something" (Oxford English Dictionary, 2017) and appeared to be a theme with which all participants connected during their interview. The process of letting go of AN differed across participants, with most of them describing it as challenging.

Nick recalled being tired of feeling ill, cold and fed up with his unrelenting preoccupation in hiding his habits and this was driving him towards relinquishing his restriction.

I was just so- so fed up of being ill, feeling cold. I was so fed up of the constant worry about hiding what I was doing[...]And that was all a bit miserable uhm... and then so that was the motivation for me to say actually I do need to make a change. (Nick: 166-186)

For Wes, listening to a former sufferer's journey, and to what changing and letting go felt and looked like, helped him in his decision to let go. Moreover, he noted that the repeated conversations with professionals assisted him in gradually letting go and opening up to the concept of recovery, perhaps by building trust in their support.

One time they had a young girl come in[...]they brought her back to talk about recovery and so she sat with us. You related you know about how things were difficult now, and how her life had changed[...]being able to see what recovery looks like and a lot of conversation with my therapist, the dietician, the doctors[...]I think just hearing the same thing over again, I think I've had to revisit similar conversations again and again sometimes, till you hear it a different way until it clicks and you're like: "Oh okay! That's what it is!" (Wes: 340-379)

Wes also connected to a feeling of relief which he learned to accommodate to:

I no longer have to listen to the torment[...]it's interesting but I'm still you know working through, learning how to just eh chill out and go from moment to moment without thinking so much. (Wes: 313-322)



Oscar did not explicitly talk of letting go. However, he described the way his recovery process began when he formed a new sense of self, together with his growing feeling of being accepted by the outside world.

I felt like when I went out of my family, I felt like eh- people outside my family appreciate me[...]In my family everybody looked at me as if I was somebody that needs help, somebody that couldn't do anything on his own, somebody that has a lot of problems. I had a lot of problems but I knew that I- I knew what I could do. (Oscar: 318-337)

*I wondered about Oscar's feelings when consistently being treated as incapable of doing things by his family members. I wondered about the impact those messages may have had on a young teenager. I remember trying to contain my sense of anger and sadness at the considerations mentioned above.*

I was pretty sure I could handle this, but I think I go through this because I had something that I really- I loved to do, something on which I focused my life and that's horses. (Oscar: 353-358)

It seemed that by distancing himself from the family environment, Oscar managed to find a passion in life and develop his self-esteem which allowed him to let go of his AN.

According to William, his habits of eating a little eventually helped him add more food to his diet and perhaps helped him to let go of unhelpful eating patterns with greater ease.

I was eating a bit and obviously if you're eating a bit that's one step closer to eating a healthy amount each day, so just in terms of practicality it was easy getting out. (William: 326-328)

*The recurrence and meaning of the phrase "eating a bit" resounded in my mind. I remembered wondering about what William wanted to convey. Was he trying to let me know that his letting go was perhaps less complex than other stories he had heard, was he downplaying his experience of recovery?*

For Edward, placing his energy and efforts in his job appeared to be necessary as a way to shift the focus onto something else.

Eh, I— I think without being wanky about it, my job is my life now[...]However, I do very much feel that my identity is very much entwined in my plays uhm[...]When I'm feeling like I'm doing well at that, great! (Edward: 737-748)

The recurrence of “very much” in this passage confirmed the emphasis often present in Edward's account. His language, “feel[...]feeling” seemed to reveal him reclaiming the felt senses which he had previously lost. Edward reported how his focus had shifted towards his career and passion, his “identity” (Oscar, p. 90).

*Given Edward's close and “entwined” relationship between his career and sense of identity, I wondered about how he felt, managed and what changes would occur when he faced career adversities. I also asked myself about the effects that “doing well” at his job had on his life.*

Edward's experience seemed to be different to those of other participants as he remembered being more spontaneous whilst experiencing AN.

That's exactly the discord! The anorexic me was flighty, it was impulsive it was crazy and manic, and I loved that and I fed into that, uhm... I miss those good days! I now kinda feel that the life that will come from that is more measured, more patient, more sustainable, but at the same time my anorexic self would have looked at that and said: “That's fucking dull! [...]And I'm finding that hard to kind of reconcile because there are bits that I say like I do enjoy about it like the patience, like the concentration, the being less sloppy but for so long I've been fighting that uhm... I've got to try and reconcile that with myself first, it's odd, very. (Edward: 831-848).

*Edward introduced the critical voice of his “anorexic self” expressing a judgment on his positive change. It looked like he may have been feeling conflicted between his AN self and his ‘new’ self who had chosen to let go of positive as well as challenging AN experiences. I remember wondering whether other participants also felt ambivalent towards their ‘new’ and ‘former’ senses of selves.*

Daniel recollected his gradual process of letting go and his newly developed interest for running.

that switched, that is really the biggest thing that then saved me, is I began to enjoy running, there's clearly you know serotonin, and dopamine, and endorphins. And I could feel it, I would eat a little bit more and, I don't know how long exactly it took, it

would be a couple of years and, I remember as I was kind of coming out of it, cause there's no abrupt like it's over! (Daniel: 696-704)

Daniel seemed motivated to let go of AN, yet he faced a huge challenge when letting go of his controlling behaviour. Daniel explained how developing new behavioural patterns helped him to cope with letting go, and to welcome change almost effortlessly.

it did start to like, as I said I kind of started ticking back up as I added more and more food. (Daniel: 872-874)

I accepted the changes that were going on a little better. (Daniel: 908-909)

However, he revealed that although still repeating some behaviours which he engaged in in the past, these now had a different effect as he actively chose to let go, rather than acting upon them.

patting his stomach or feeling his stomach [speaking of his father] ...I still do all of that, several times a day but I let it go, I don't do anything about it. (Daniel: 1193-1195).

The way the experience of AN changed for some participants from feeling subject to the rules AN dictated, to feeling able to take courage and let go, struck me. For some of these men letting go appeared to be a conscious choice, for others a more natural process.

## **4.2. Master Theme II: Me and the World**

This master theme seeks to shed light on the role of relationships within the interviewees' lives during AN, including romantic relationships, family and self-perception within society.

### *4.2.1. Romantic relationships*

At the time of the interview, Daniel, Edward, Liam, Oscar and Matt were involved in long-term romantic relationships. These men appeared to rely on their partners, and referred to their past and/or present romantic relationships as key in their journey with AN. Their romantic relationships emerged as a source of motivation and hope for the future, of achievement, and self-confidence, enabling them to acquire strength to let go of some perhaps undesirable behavioural patterns. These relationships seemed to drive their MoC.

At other times, however, the sensations which emerged from their relationships seemed to promote feelings of anxiety and pressure.

Daniel and Liam often mentioned both their former and present partners during the interview. Daniel described the way he felt compelled to maintain a specific body appearance and excel in other areas of his life, due to his perception of his former wife and her social background. This endeavour towards “perfection” exacerbated his anxiety and panic attacks.

and it was almost too much with the first wife, because we weren't that compatible, she was the 90210 she actually came from a very wealthy family, all these different things. I think it was too pressured for that sort of perfection. I began sort of projecting perfection and control in other areas, like studying compulsively which certainly isn't a bad thing [giggles] (Daniel: 1123-1132)

Comparably, Liam seemed to feel impacted by his former girlfriend's judgment:

I just really assumed that she broke up with me because I put on weight (Liam: 844-846)

once we stopped being together, and I was kind of free to do anything I wanted, I kind of did, like I felt that kind of freedom of being able to throw up whenever I needed, and to take drugs whenever I wanted so I think uhm, yeah, (Liam: 885-888)

The dynamics of Liam, Matt, and Edward's romantic relationships seemed to shape the way they experienced their AN. For instance, Liam stated that he wanted to try to “fix” (528) his AN for his girlfriend and his parents, signalling a sense of obligation.

I do it for my girlfriend's benefit or my family's benefit, for them. I need them to see me doing something 'cause it's not, it's not something I'm proud of. (Liam: 658-660)

Liam's words seemed to indicate he may have felt forced to act upon his eating behaviours, to please others, although he had not found an inner MoC. His choice of words is interesting, when using the verb “to fix”, I wondered about his perception of the self being broken. Moreover, he stated wanting to “do something” for his girlfriend's and parents' “benefit”. This phrase might suggest that he was searching for external drives and was not able to grant himself reasons to end his self-destructive behaviour.

*I wondered here whether Liam's motivation to implement some improvement for someone else might have been an initial step towards strengthening and acquiring inner motivation.*

Matt too described the essential role that his girlfriend played in relation to his eating patterns.

the best that I can hope for at the moment, is when my girlfriend comes back it will be so nice to see her again[...] I will just slip back into eating, maybe her eating pattern.  
(Matt: 732-738)

The mere presence of his girlfriend seemed to have a positive influence on Matt's eating habits, which worsened when she was away for extended periods of time. Similarly, Daniel and Liam:

all this transition and stuff to eating salmon and things like that my wife having grown up in different continents<sup>4</sup> she's always enjoyed soups and more seafood[...]more vegetables (Daniel: 1285-1289)

like we went food shopping together, we sort of planned our meals and cooked.  
(Liam: 926-929)

*I wondered whether the men's eating habits perhaps improved in the presence of a loved one due to a nurturing effect on his self-worth. They felt more relaxed and perhaps distracted, or, in line with Liam's statement above, maybe they may have felt pressure to please his partner, perhaps due to fear of being abandoned because of his AN.*

According to Matt, his family did not interfere with his life in relation to AN, as they also relied on his girlfriend to support him.

but eh, if it wasn't for my girlfriend I would be you know...I think they back off because they know I've got my girlfriend...they trust her. (Matt: 784-786)

---

<sup>4</sup> Information changed for confidentiality.

It looked like Matt's family believed that his girlfriend could take care of him. Matt described his girlfriend as aware and accepting of his eating patterns and rituals. He explained that their relationship also permitted him to displace his attention away from food intake.

I51: I think her being patient and tolerant to it, and accepting it and never really kind of-

R52: Challenging it?

I52: Trying to change it, or challenging it is, it is helpful, it-

R53: In what way?

I53: That, I still have someone, that I can still be, and when she is around me it's not as- it's still very dominant and it still takes up a lot of the conversation, it's very, it's- it won't be going anywhere sort of thing, but it's still and it makes me think about something else for once (Matt: 428-437)

*Perhaps Matt was not ready to be challenged by someone who would want him to change his attitude, even if for the betterment of his health.*

Being transparent with his girlfriend seemed to allow Matt to feel accepted. However, his statement also showed some controversy. He noted that whilst he and his girlfriend openly addressed his AN, she also acted as a distraction. Furthermore, he stated that her tolerant attitude helped him, although according to him nothing was going to change his relationship with food. It seemed that their acknowledgment of the AN in conversation did not have a positive effect, as the AN was "not going anywhere": Concurrently, his girlfriend's mere presence was enough for him to change his eating habits. I wondered whether this controversy might suggest Matt's ambivalent stance with regard to his AN experience. His relationship appeared to be like a double-edged sword: his partner's non-interference and tolerance towards his eating habits might suggest that she acted almost as an accomplice in his behaviour, yet she seemed to be the only person who could make Matt feel accepted.

Edward acknowledged the weight of his partner's role in his life.

I hate to say it but Laura<sup>5</sup> has been my saviour. (Edward: 557-558)

He seemed to perceive her role as crucial, to the extent of being almost afraid of dependence.

---

<sup>5</sup> Given name changed for confidentiality.

I think that a huge thing was that I found my now girlfriend[...]she makes me incredibly happy. I'm worried because that's putting my happiness in someone else's hands it's not taking responsibility for my own happiness[...]but I'm in a weird place because I'm so fragile with Laura and, I mean we're great! From my point of view, we seem to be going really really well! it's been a huge thing for both of us that I've been putting my happiness in her. (Edward: 336-349)

*I felt overwhelmed when listening to Edward's words as he described putting his happiness into Laura's hands. The phrase "I hate to say it" made me wonder about the feeling of admitting removing his own responsibility. I thought about Edward's previous experiences characterised by exertion of intense control on his life. Furthermore, the use of the word "huge" struck me and my immediate thought was its clash with Edward's slender physicality. He frequently used the term, and other words which carried emphasis and evoked large dimensions. I tried to put myself in his shoes, a man who had struggled to eat "huge" amounts of food and who battled against becoming physically bigger. This led me to consider how perhaps being able to only articulate such terms without experiencing physical consequences may have been comforting, freeing or maybe he did this to convey confidence. I noted that, in both Matt's and Edward's experiences, their girlfriends appeared to have much responsibility and pressure. I wondered who supported them.*

The passages above describe the ways in which the relationship between Liam, Matt and Edward and their AN can be understood in the context of their romantic relationships.

Edward was the only participant making specific references to his sexuality. He explained that his sexual drive had increased in his new relationship in parallel to his progress on the recovery path.

to now getting sexual urges, to being very sexualised being obviously in a committed sexual relationship. (Edward: 863-866)

Although Oscar did not engage in a relationship during his journey with AN, at the time of the interview he was married and a father.

So I uhm... I've always dreamt a family[...]So they tell me, and they mmm they tell me every day that they need to see me and my wife being happy together. They

need to see me and my wife hugging. Or they need to be kissed by me and I can feel this. (Oscar: 620-635)

*Whilst listening to his words I sensed a feeling of insecurity and a need of love from his family.*

It seemed that the love Oscar received from his wife and children nourished him and provided sense of acceptance that contributed to his role of husband and father.

#### *4.2.2. Parent-son relationship*

Parents' involvement or lack of it emerged in the participants' narratives. The way they described their relationships and the dynamics within their families seemed to echo the significance they had within their experience of AN.

For example, Nick and Liam's parents appeared to have little or no involvement in their sons' journeys. Nick explained the process of opening up to his parents and attributed their non-involvement and their lacking ability to address feelings, to cultural reasons.

telling my parents was completely[...]against everything I've ever learnt[...]I mean they knew I was ill but we just didn't talk about it. Because we just don't! Sorry, that's making them sound awful[...]it's not from a lack of care or lack of love it's just from a lack of...not knowing how to and coming from the same kind of culture where you just don't talk about feelings. (Nick: 605-621)

According to Liam, his parents only became aware of his condition when he was forced suspend university.

my parents were completely unaware that anything like that was happening so I think them finding out uhm, yeah even just, yeah that, that was a big big moment certainly (Liam: 324-328)

*I remember wondering what pushed Liam to keep his struggles 'secret', was it embarrassment, pride, fear of losing control or perhaps feeling afraid of being misunderstood?*



Although now aware of Liam's MH issues, his parents appeared disinclined to intrude in his regimen.

it upsets their life obviously but part of me thinks it's just because they were bored and it's not, they just kind of have resigned themselves that they can't, and it's my fault I don't let- I probably haven't let them help. But people just resign themselves to the idea that they can't help! (Liam:1037-1051)

Underpinning Liam's ambivalence towards being helped seemed to be a sense of disappointment discernible in his words and tone of voice, when describing his parents' resignation.

*I wondered whether Liam's parents might have not known how to support him and perhaps were tired of feeling helpless.*

Liam felt his parents gave up on helping him because he did not allow their support and did not communicate his need for help. This might suggest that his lack of trust and feeling of abandonment kept feeding into undesirable behaviours.

I think my sort of parents have stopped asking me about it and they're definitely turning a blind eye towards any of this. And I think my ex-girlfriend she left because of this, and my two best friends moved out because of it. And it's obviously very upsetting. (Liam: 1034-1040)

*I wondered about Liam's feelings of self-worth whilst he articulated a sense of abandonment.*

Liam's words seemed to echo a tremendous solitude and a sense of powerlessness. "Turning a blind eye" suggests indifference and unavailability. For Liam, parents and friendships seemed meaningful and he expressed frustration at the realisation that AN was separating him from close relationships.

knowing that it was this thing, this eating disorder and stuff meant that I don't see someone anymore then- someone doesn't feel they want to hang out with me anymore, I think that really kind of annoys me; makes me annoyed at myself and annoys me, I'm annoyed at this thing. (Liam: 1067-1079)

Liam repeated the term “annoyed” suggesting a sense of frustration with the situation. His use of language is interesting. When he said: “makes me annoyed at myself[...]I’m annoyed at this thing” it seemed to reflect his confusion between his own, and AN’s responsibility in terms of his choices and their consequences.

Nick too experienced frustration when realising the ways his experience of AN was pushing him further away from family and friends. However, the prospect of becoming more isolated seemed to fuel part of his drive to act on change.

I was so fed up of constant, not, not of the depression, but of the loneliness of the complete social isolation. (Nick: 167-170)

Wes described the way his family’s constant encouragement and engagement helped him gradually veer towards seeking help.

My family was saying almost daily like: “You need to do something about this!”[...]and so eventually I, it wasn’t easy at first. (Wes: 266-270)

Whilst being unwavering in presence and care, Wes’s family’s words seemed to carry an understanding that it was Wes’s calling to initiate change.

According to William, his parents could not have guessed about his illness, as they deemed it specific to females. Moreover, he explained that his eating behaviours did not fit the stereotype whereby a person with AN starves themselves.

And my parents uhm[...]they wouldn’t have presumed that I could be anorexic cause I was a boy. That played into it and also because I did eat, and the idea you have of someone who’s anorexic is somebody who doesn’t eat at all, who starves themselves. (William: 879-883)

William’s experience seemed to manifest more on a psychological level, which may be more unknown or difficult to make sense of for people who may not have the knowledge or experience of AN.

Daniel and Wes recalled the vital role of their mothers, and how they were present in their sons’ battles with AN.

she was my main support for a long time (Wes: 841-842)

These two men remembered their mothers showing their love and concern by encouraging them to seek help. Furthermore, Daniel illustrated the extent of his mother's concern when she began adopting similar hiding behaviours to AN sufferers, to help her son gain weight.

she also admitted later, 'cause I had my little mini fridge, that she was slipping whole milk into my non-fat milk[...]it's a sign of a good mom. (Daniel: 564-570)

The men's relationships and interactions with their fathers distinctively differed from those with their mothers.

my mum was okay but I think my dad[...]he's just an older generation he's a man, just did not...did not cope at all. (Liam: 333-334)

Edward, Nick, Wes, and William, made no specific mention about their fathers. Liam, Oscar and Matt revealed having problematic relationships with their fathers.

he took away all my control and he made me eat six times a day and his portions, he took sadistic pleasure from the fact that he would make the biggest portions. 'Cause he had the 'feeder' thing. (Matt: 815-818)

Oscar, started a family of his own. His descriptions of his values regarding family dynamics, functioning and his role as a father appeared in sharp contrast to that of his own father.

He says: "The only thing I can do is to work. To work to earn money, to work on my business." I think that this is completely wrong, if you make a family you have to work for your business, but you have to work for your family[...]If you don't want to work with your wife for your children, don't do a family, because your family needs you! Your family needs money to live, but your family needs you! So even if I am the richest man in the world, if I have my children that have a lot of problems, I have my children that are not happy, I have my wife that is not happy, why did you work? (Oscar: 538-558)

Again, Oscar's statement showed the awareness and importance of his role as a father in his new family; something he felt was lacking in his family of origin. The repeated emphasis placed on the term "need" might have suggested that his own needs were not met, and

underpinned his own beliefs about fatherhood and a newly developed sense of responsibility.

*I was fascinated by the variety of different ways that families emerged within the men's stories about their AN journeys. I had a sense of parents wanting to provide support but feeling that their sons blocked their efforts at times. I also had a sense of the ways in which some families felt powerless to have an impact on their sons' AN 'regime'. I was curious about the feelings of solitude and frustration that this may have brought to the sufferers and to the families.*

#### 4.2.3. Sense of shame and loneliness

All participants connected with their sense of self in relation to the people around them. Most of them revealed that loneliness marked their journey with AN. When recalling the feeling of isolation, William, Daniel, Nick and Liam described experiencing shame and embarrassment around others. However, the way the men made sense of these emotions seemed to be different in their individual experiences.

Matt, William, Nick, Daniel and Wes withdrew from their families and social circles to keep their calorie intake under control, to preserve their command over their thoughts and actions, and to exclude others from interfering with their AN behavioural patterns.

I think that's where it started: the battle and the struggle to avoid the meals and cut down on it. That became the first motivation and that's where things started to change and take a dark turn, like the calories, how I was going to get through each day to avoid eating[...]Then I stopped going to the gym, it stopped being about being fit and healthy. (Matt: 315-321)

Once you get trapped in something like anorexia or any other eating disorder it just- because you become so obsessive over it that kind of drives you to become lonelier and lonelier because you have to get through it by yourself. (William: 229-232)

William's drive towards solitude seemed to develop from his need to feel in control. The self and AN seemed to fuse into what sounded like an order or perhaps a self-imposed rule to become stronger through being more independent. Despite having initially sought isolation in order to keep in control, the sense of solitude for these men began to feature prominently in their existence.

I was extremely fucking lonely. (Nick: 337)

I think the illness isolates[...]makes you very, well it made me very socially awkward and I missed out on a lot of my high school[...]it's uncomfortable for me to talk about it but it does, it makes you, you end up alone with the illness that's what it does yeah! (Wes: 55-61)

Daniel, Matt, and Wes portrayed their discomfort and self-hatred, feeling unaccepted and ashamed around others. Their words suggested a restriction to their expression of self and their identity.

I didn't like changing in junior high locker rooms, I felt bad about my weight I felt, eh, I felt bad about my weight I felt, I'd grab my stomach a lot and pull on my double chin and like try to, I remember trying to stretch not literally cut it off, I was never a cutter but I would stretch it to see what it would look like. (Daniel: 325-333)

Feeling unaccepted and misunderstood seemed to be linked to the development of a sense of self-hate for some of the participants. For instance Wes said,

I...self-loathing. Because I started the- I always felt that there was something wrong with me. (Wes: 203-205)

Over time, Wes and Daniel's self-loathing and sense of unease around others appeared to change in the direction of hope. Perhaps they were beginning to experience themselves and life in a different way.

when I'm not thinking so hard and when I'm not having all the negative thinking, and focused on what I don't have...and, all the things that I think are wrong with me and why did this happen and why, and when I'm not, when I'm just living, when I'm just you know...the more the positive stuff comes in. That's when I know it's getting better! (Wes: 503-511)

However, during Matt's interview, he seemed to be overwhelmed by anxiety, and hope appeared to be deeply buried and less accessible for him.

The complete anxiety and self-hatred caused by eating, you know I wanted to do anything- I still want to do anything to avoid that. (Matt: 322-324)

William recalled the feeling of embarrassment at being labelled “anorexic” (336, 338) and being associated with an illness most commonly related to females was a reason that led him to slowly change his eating behaviours.

I was embarrassed, and going to a boys’ school, being compared to a girl especially when you’re thirteen or fourteen is really embarrassing. (William: 356-359)

that made me feel very bad, and I think that made me realise something had to change. (William: 413-415)

In contrast to the other participants discussed above, Liam’s sense of solitude and helplessness was overridden by a stronger feeling of shame.

I think I was that miserable at the time[...]I was all of a sudden really embarrassed and that sort of feeling of shame is sort of there and now I associate any sort of weight gain with that intense shame that I felt. (Liam: 409-418)

Liam felt embarrassed by his appearance and dreaded any weight gain, upholding his ED. He described how shortly after a brief social withdrawal at the beginning of his journey with AN, he had been able to keep a seemingly active social, romantic and professional life.

I wasn’t trying to fix the eating disorder[...]just more motivated and fix other areas of my life like university or like sort of getting more friends, or now like work. (Liam: 529-533)

Liam did not attempt to confront his MH illness and placed his attention on his social life and career. It is interesting to notice the way Liam seemed to compartmentalise aspects of his life perhaps to manage his sense of self.

I needed something positive to happen uhm, because it was just too negative, it was too unhappy so yeah it kind of all just, things just started getting a bit, even marginally a bit better. (Liam: 570-575)

He admitted battling within himself, feeling discomfort, and a motivation to find some positivity in life as he felt almost helpless toward his ED.

*Liam's choice of words struck me when he said "fix" his ED or referred to "fixing" other areas of his life. I associated the term with an unsophisticated procedure, which could be accomplished by simply following the instructions. I asked myself whether he admitted not trying to "fix" the ED because it would require a different quality of effort and commitment, which he might not have been ready for.*

### **4.3. Master Theme III: Connecting**

This master theme stemmed from participants' urges towards candour and honesty with themselves and others, for instance through social media, through reinventing themselves, or through finally managing to get in touch with their true feelings. The need to connect with others, share their experiences, and attune to their feelings seemed to be one of the effects of for example, feeling tired of being concerned about their health, of hiding their behaviours, of loneliness and isolation, of feeling a loss of connection within themselves, fearing death and wanting a different future.

The theme 'connecting', contains the ways the interviewees' experienced the concerns and feedback of those around them, and the effect this had on their own thoughts and behaviours. This theme also includes interviewees' explorations of their experiences and understandings of recovery and motivation. Although this theme allowed me and hopefully will allow the reader to appreciate the idiosyncrasies of each experience, a strong sense of uncertainty around recovery and MoC appeared to be shared amongst interviewees.

#### *4.3.1. Changing awareness*

Most of the men recalled a time during their experience of AN which corresponded to a change in their perception of self. This change seemed to trigger a shift in their efforts in relation to AN. Edward and Nick both remembered feeling numb.

that was my biggest wake-up call because I was doing my dream job[...]and I just felt nothing! I just felt hollow and directionless[...]I was like I don't want to die like this.  
(Edward: 207-213)

I'm a football fan[...]we scored a last minute, tried to win, and I just didn't feel anything[...]also I go to the cinema a lot and just watching dramas which I knew should be affecting me weren't. (Nick: 124-136)

Their perception of losing touch with themselves seemed to spark their drive in choosing life and wanting to change in relation to their journey with AN. Although the men had been aware of AN's risks before, they perhaps seemed to become more real and possible.

Life, and new events in life, seemed to play a role for some participants. For instance, Edward's new role in life and newfound responsibility prompted his process of recovery.

I'm an uncle now! I have to sort my shit out now! (Edward: 235-236)

On the other hand, William revealed his apprehension about others' judgments and concerns seemed to act as an internal barometer for his MoC. The worry of being perceived as something he did not really want to be perceived as contributed to making a conscious decision about recovery.

I was going swimming and she compared me to a skeleton, and that made me feel very bad, and I think that made me realise something had to change 'cause I didn't want my mum[...]excessively worrying about me (William: 410-417)

William's memories about his school peers labelling him as anorexic also contributed to a swift change in direction.

if I said: "I don't want to eat or something", I remember clearly a friend saying: "Ah! William's anorexic, you only eat that!..."I didn't describe myself or identify as anything like that, so when someone actually said that, was quite shocking! (William: 333-341)

William's experience of being stigmatised and feeling embarrassed seemed to have had important implications for his motivation. Nonetheless, due to his fear of being seen as someone (a boy with AN) with whom he did not want to be associated, he admitted not seeking any help. William's narrative confirmed the lack of information around the illness and the stereotypes which are linked to it (MacLean et al., 2015).

*I remember wondering why it was "shocking" for William. Did it come to him as a surprise to*



*be labelled? Or was it his sudden realisation of being associated with a certain category to which he did not want to be seen to belong? William's efforts to recover from his ED had been successful. I wondered about the implications a similar situation could have had on someone who could not manage to recover from the illness alone.*

Daniel and Wes did not speak about key moments or “wake-up calls” which fuelled their MoC in their experience of AN. Instead, they both described a long passage towards recovery characterised by alertness and receptiveness to internal and external stimuli which impacted on their MoC.

I think it was very gentle, a lot of conversation, and my own consideration about it and, eventually, eventually arriving at where I needed to be so, it takes time, in my case it took time. (Wes: 375-379)

Daniel and Wes's experiences might suggest that loosening their routines and making sense of what these meant for them at that time was very difficult. As Daniel often said throughout the interview it took a while to “seat” the control (Daniel: 1050).

Liam remembered having experienced situations where he felt prompted to change:

I think things just, things just hit rock bottom really with work, with university, with friends and everything and it did get to a point where, I did want to try to actively not stop everything, but at least lessen the negative impacts it was having. I did sort of make steps to, to get into therapy and go to the doctors, try medications. (Liam: 259-267)

Liam's words reflected both his sense of uncertainty, and his great determination. I wondered whether some participants, like Liam, may have not been ready to allow their awareness to be experienced as a “wake-up call”.

there was probably nothing[...]very little things that are more important to me, unfortunately than just keeping that weight off like uhm...and that was definitely the case at that time. I was kind of...that was all I was thinking about. I am not even sure how aware I was of death or negative side effects at the time. (Liam: 225-232)

Liam seemed to be making sense of his felt sense during the interview, as he articulated his experience. His weight and control over his physical shape seemed to be at the forefront of his mind.

I know there's lots and lots of will power needed to do anything like this, I'm aware of that and, I do have the will power to fix it actually. I don't want to go through the process of fixing it because I know that's going to involve probable weight gain, it's going to involve just releasing that control. (Liam: 687-693)

This phrase showed Liam's inner battle as he articulated the contradiction between feeling strong enough to change and the behaviours he may have not wanted or felt ready to engage in.

*What would letting go of control have meant for Liam? I wondered whether, at least initially, he might have been able to channel the control into actively wanting to gain weight like Nick had done, and perhaps then wanting to succeed at recovery?*

Matt too seemed unprepared in terms of change. His experiences distinguished themselves from the rest of the cohort, in that he seemed unable to use his insight and experience of AN to seek help or gather MoC.

And no one can possibly enter your mind and unravel all that[...]there's no way to understand it from the outside and that's what makes it so difficult you know. Everybody knows that there's a problem with me[...]but anything they suggest anything; they ain't gonna do it, they will never understand the full extent of what goes on under the surface and that's why it's so hard. (Matt: 277-284)

Matt seemed very much aware of what was going on within, but appeared perhaps helpless and reluctant to let go of what AN meant for him.

the one time you feel satisfied is even if you're starving hungry, I mean you're aching, your body is falling apart, you feel satisfied like yes that was good, I didn't eat anything, and obviously that is really unhealthy, it is, you know this! (Matt: 236-239)

*Whilst listening to his words, I was wondering whether Matt wanted to preserve a sense of specialness, distinctiveness or heroic work.*

one of the only mental illnesses where you can stare, where you can watch it happening but you can't do anything about it. (Matt: 604-606)

Whilst Matt's awareness appeared to be present, his ability to move towards change appeared frozen, making him a spectator of his own experience. His sense of helplessness evoked a sense of impatience in me. Matt seemed to have passed the baton to his AN allowing it to take charge of his life.

any way to help me would be doing, would be putting on weight good or bad, would be changing, would be trying to get change for that, and that for me is my worst nightmare, that is what I'm trying to avoid every day. That's what is yeah, you want, you want, you want, I mean I don't want to stay the same but I have to. (Matt: 866-874)

Matt sometimes described AN as dictating the rules which he felt compelled to follow. His language suggested fusion between his cognitions and AN, perhaps contributing to his sense of helplessness towards AN.

#### *4.3.2. Coming clean*

The participants' EDs had sometimes led them to conceal themselves, their behaviours and thoughts and their AN. During interviews, most conveyed an urge to maintain their authenticity. 'Coming clean' can be understood as the participants' growing need to be congruent with their sense of self which was informed by self-acceptance. For example, before Nick's interview began, he told me he wanted to be open about his experience and preferred not to use a pseudonym for confidentiality purposes. Similar requests were voiced by other participants too. I explained that, whilst intending to protect all the participants' identities, I was abiding by the ethical code of conduct. Additionally, using pseudonyms would enable participants to change their minds in the future regarding protection of their experience.

you know clearly we all wear masks all the time and we present different versions of ourselves[...]but it's trying to be, trying to have less, less split between them I suppose[...]so we talked about stupid things like not using a pseudonym and you know I occasionally talk on social media about how I'm feeling which is something I've never done before eh (Nick: 588-600)

Nick's language immediately resonated with Carl Rogers' "self-actualisation" (Rogers, 1961). Rogers' quote, "The curious paradox is that when I accept myself just as I am, then I can change" (p.17) made me question whether, within Nick's experience of AN, his striving towards genuineness was an essential component of his MoC, or a consequence of this journey.

*I wondered about the term "split" and connected it to another interesting divide: Nick appeared discreet and withdrawn from others during his journey with AN (or perhaps hoped to be perceived that way). This was in sharp contrast to my perception of the internal loudness and intensity of his AN voice.*

Throughout his interview, Nick explained that he was not only hiding his AN and struggles from the external world due to a stigma attached to being a man with AN. He explained that confronting his feelings had been unknown to him whilst growing up. William's experience seemed to resemble Nick's, in that he had developed a novel insight into his own emotions through self-acceptance.

I think along with coming to terms with having been anorexic, that kind of opened up a new vocabulary for me in terms of emotions[...]And since I can talk about something as serious as that, I can talk about most things. (William: 934-940)

Opening up "a new vocabulary" might suggest being able to understand one's own emotions and being able to communicate them. Nick's and William's contributions to the media community allowed them to give support and sense of connection to other sufferers. According to their accounts, during their battle with AN, it was likely that they may have needed someone to connect with, and with whom to find a sense of commonality. Like Nick, some of the other men described the ways they had chosen to express their long-hidden struggles, and how they combined this with raising awareness around EDs in males. Daniel and William wrote about their experiences on blogs and newspapers. Edward introduced his experience into his scripts to raise awareness of the struggle of males with EDs in his plays. Although Liam had not exposed his battles publicly, he reported hoping that the interview experience would encourage him to reconnect with his motivation to recover.

Daniel remembered when he first began writing a column about his journey through his AN.

it was so, it wasn't just connecting it was, I felt good about it[...]and other times I was uplifted in hearing other people. I guess a bunch of things happened if I'm honest.  
(Daniel: 129-135)

Revealing his truth and receiving positive feedback seemed to support Daniel's need for acceptance and connection to others. Offering his experience in writing seemed to have a beneficial effect on his sense of self-worth and at the same time provided encouragement to other people.

You can get through this! I got through this! You can do that!" and so I was trying to be that kind of person (Daniel: 163-165)

Helping others through the disclosure of their own experience was a common theme across interviewees.

I think this is something that can heal people[...]that people that had that kind of experience can be maybe an example or something that other people can look at.  
(Oscar: 27-33)

I've always kind of have been heavily involved with eating disorders and the eating disorders community. So I work for several organizations<sup>6</sup>[...]I want to help. I find it very therapeutic but you know if there's any way I can help, I sort of want to really.  
(Edward: 41-55)

Through his words and pace, Edward seemed to evoke his "need to be doing rather than not" (86-87). His involvement in the ED community seemed to have a cathartic and empowering effect on him.

*I wondered whether Edward's contributions also functioned as a catalyst for his increasing ongoing MoC. He seemed to have identified a role which gave him purpose within the ED field.*

Some participants mentioned that the dearth of literature on male experiences of EDs drove them to discontinue their secretiveness. This phenomenon could be linked to the need for connection and acceptance which Daniel had hinted at.

---

<sup>6</sup> Names of organisations have been omitted for confidentiality.

let alone eating disorders in men[...]I believe there's only like one or two studies that kind of glossed over eating disorders. And I thought, it's something that really needs more attention because obviously, those who suffered it and those who also suffered it know what it involves and how much and how serious it is. (Matt: 25-30)

Nonetheless, as William expressed, he was "so worried about other people finding out about it." (323).

Coming clean had been a demanding and an almost inconceivable target to reach. William's silence seemed to be characterised by the shame linked to the fear of being labelled and perhaps misunderstood.

this is interesting, I didn't tell anyone about it until I was twenty so it took five years for me not to feel embarrassed about it. (William: 541-543)

William had not revealed his experience to anyone for many years after he recovered from AN.

what first inspired me to first open up about it was that I met uhm, a friend who also suffered from Anorexia and she came out[...]talking with her about it really helped because I realised it wasn't something I should be ashamed about talking about and just uhm, sharing experiences with someone was really helpful. So that's what made me much more comfortable with it now I, having this kind of sense of commonality. (William: 552-562)

For William, listening to his friend, and her ability to voice her experience, discredited some of his own prejudices about AN. William's statement might indicate that connecting with the authenticity of other sufferers' experiences can act as an inspiration and encouragement towards openness and self-recognition.

Wes explained he had been discovering a new self and was coming to terms with his transformations by actively conceptualising his new persona.

I don't think I'm the same as I was. Uhm, now it's just, it's different I've sort of kind of, what I'm trying to do is re-invent myself, sort of change, start over because I, there really wasn't any other option besides just really starting over. (Wes: 556-561)

The repetition of the term “start” and the concepts Wes expressed such as, “I don’t think I’m the same[...]it’s different[...]sort of change[...]really starting over” suggested movement and conscious effort, allowing me to further appreciate his perspective. Through a process of self-discovery, Wes had grown to accept himself. Wes’s awareness of his own process of self-acceptance moved me; he was like a butterfly coming out of its cocoon.

In contrast to the men mentioned above, Liam’s attempts to come to terms with his experience had been to some degree less effective in spurring his motivation. Reaching out for his partner’s, family’s and friends’ help had perhaps not generated the outcome he needed or desired.

I need to get better relationships! (Liam: 888)

*Listening to Liam’s failed attempts to come clean was heart-breaking and disarming for me. I remember feeling a sense of disappointment and sorrow. Part of me grappled to stay within the researcher’s role and not shift into a therapeutic stance, which admittedly was more natural for me.*

Although Liam had shared his struggles with family and friends in the past, he was unwilling to continue to do so at present.

if I had it my way no one would, no one would know anything about this. (Liam: 1073-1074)

The repetition of “no one”, seemed to award a sense of firmness to his thoughts. Perhaps feeling let down by others had led Liam to choose to retract. In contrast to his other relationships, that with his AN had been steady, and perhaps this consistency facilitated a stronger relationship with his AN. Besides his challenging relationship with his appearance and food intake, Liam’s sorrow seemed to encompass the interpersonal disappointments he had experienced.

I’d kind of rather just remain, just ignorant even though do you know what I mean, kind of ignorance is bliss kind of thing. (Liam: 400-403)

This phrase represented Liam’s stance towards AN’s repercussions on his body and mind. It also might have reflected the way he felt treated by those around him.

#### *4.3.3. Reflections on motivation and recovery*

All the interviewees reflected upon their motivation and recovery process. Although they carried unique memories, which involved their own distinctive teachings, sensations, beliefs, and approaches to their lives, some men seemed to share similar views and certain parts of their experience showed a resemblance. For most of the men, recovery had been a laborious process.

recovery is really fucking hard, and really awful at times, but you sort of have the hope that at some point it'll get easier...I sort of know that being ill was not fun[...]it stopped me doing, it stopped me doing things that I enjoyed and stopped me doing things that I felt gave me purpose. So, so recovery means the lesser of two evils I suppose. (Nick: 275-285)

This passage seems to show Nick's thought process, whereby, despite battling against a challenging opponent, he remained driven and fuelled his drive through his memories of AN. The ways he had felt held hostage by AN, living a restricted life, were reflected in his words when he referred to purpose in life and repeated the term "stopped". Furthermore, Nick used a metaphor, recalling a childhood experience to describe his recovery path.

recovery process[...]so I used to do a lot of hill walking when I was a kid. Sometimes you'd be walking up the hill you think it was the summit when actually it's a false summit and there's the next one[...]recovery's felt a lot like that[...]that every time you seem to get somewhere it gets hard and you have to find new motivations to do stuff. (Nick: 81-92)

The involvement of a child's perspective is interesting in the context of a parallel which can be drawn with the experience of the adult man and the child's needs which need to be met. Perhaps the man, like the child, expected some "scaffolding" (Vygotsky, 1978) to restore his initial inspiration. That "scaffolding" could have helped strengthen Nick's ability to identify the tools needed for his motivation to rise and become internalised. It seems worth noting that both Nick and Wes reminisced on childhood experiences when exploring their recovery process. This might shed light on their vulnerability and the need for direction which characterises this illness. The recovery process in Wes's experience was long-lasting, and mirrored the struggle he had faced during AN. He compared his MoC to a "seesaw" (427),



I would like sort of slide in and get all this momentum and then slide back a little here, it's hard to explain... on the whatever day, typically in my case, I would get some good momentum, I would seem to be doing well and then, I would slide back for a few days. (Wes: 427-433)

*The use of the term “slide” is fascinating. By definition, “sliding” entails a smooth, continuous, and effortless movement (Oxford English Dictionary, 2017). Wes’s “slide” and “seesaw” analogy, made me think about being lifted and dropped, rather than sliding effortlessly. I imagined the AN sitting opposite him, taking his power and allowing him to be lifted and then making him fall. I was curious as to whether this movement could be conceptualised as a mirror of his ambivalence in terms of recovery. I therefore wondered about his use of the term “slide” and Wes’s rationale for this. It seemed like the two terms were contradictory. His description made me question whether he did not feel grounded within the recovery part of his experience. His “seesaw” and sliding made me think of a movement in and out of recovery, rather than smoothly. What would Wes have needed when he felt he was “sliding back”?*

Moreover, Wes articulated his perception of the relentless presence of the recovery path as a “journey” (457) within his daily life. He explained that he used “self-talk” (466) to stabilise “motivation, moods, hope, gratitude, when those went up and down” (473-474).

Daniel recollected “running” (718) as a way to control his weight. Exercising allowed him to reintroduce some foods in his diet. The process of eating a little more and running was new to him and it gradually seemed to make him feel more confident in his physical appearance and performance, with which he had struggled since a young age. He had not been a physically active child, and “running” became an achievement which built up his self-esteem and seemed to help him cope with his bodily changes.

but it just got me eating more and more and loving running[...]I was becoming such a good runner, I was placing really high[...]I was eating more! (Daniel: 718-723)

This route gave Daniel permission to explore different kinds of exercise and his physical limits, and discover new foods to which he had not been exposed before. His ambitious mind seemed to slowly channel his need to control his body weight and appearance into leading a healthier, more balanced life.

I felt physically better uhm, and I know that seems at odds with like staying in control. I didn't notice that my weight was going up 'cause I was running[...]because I drifted out of it over a couple of years but it definitely had to do with fuel and then it made me able to run longer which made me feel better. (Daniel: 866-879)

Edward's inherent curiosity and perhaps ambition, which emerged throughout his interview, seemed to motivate him to value the future, and informed part of his recovery path.

I'm interested to see how I feel about this period in three years' time. (Edward: 540-541)

His MoC seemed to be characterised by the struggle to reconcile competing needs.

it's success, if I feel successful, that's cool and I think anorexia, when I was winning at it made me feel successful, like I never felt before...I love that. (Edward: 436-439)

As the other participants mentioned earlier, Edward experienced *rewarding* feelings when managing to firmly adhere to the AN rules. Through the repetition of the term "success[...]successful[...]" he offered me an opportunity to enter his inner world and get a *taste* of how he experienced success and how important feeling accomplished was for him. I wondered whether he would feel more *accomplished* if his hunger for success were satisfied through finding other drives in life.

Apart from Oscar, all the men seemed to carry their experience of AN in their everyday life decisions and actions, suggesting that they seemed to perceive recovery as an ongoing journey. Besides ambivalence, a common phenomenon in AN (Williams & Reid, 2012), some of the men seemed confused about how to operationalise recovery. For instance, Liam voiced that part of the reason for taking part in the study was an attempt to reconnect with his recovery experience, hoping to understand more.

I feel a bit lost in it at the moment, I feel like[...]I've sort of stopped understanding why it's happening or what I need to do, so yeah like I said I think this is just quite a nice way of just consolidating everything and getting a better idea. (Liam: 71-76)

Liam believed that taking part in the interview may have assisted him in making sense of his experience. This thought seemed contrasting with his avoidant attitude (p.105, Liam: 529-

533, p.108, Liam: 687-693), signalling the ambivalence which Liam seemed to be experiencing.

With regard to ambivalence in relation to the men's MoC, it looked like most of them had experienced motivational conflicts.

I'm motivated to get better, but I'm not motivated, I'm motivated to be better but I'm not motivated to, to get better do you know what I mean? (Liam: 696-699)

Liam's words sounded chaotic as he expressed wanting to get better. He seemed to feel unprepared to bear the cost of change despite wanting to get better:

I mean no, again I still don't, I don't think I still wouldn't be able to tolerate some weight gain (Liam: 715-717)

It was striking to notice the differences amongst the men with regards to their sensations and thoughts on recovery,

there is something about at times just being able to, just being able to, just go with things being liberated and it doesn't give you time, not having time to think about the consequences it comes back to the point about you know being, being spontaneous around food. (Nick: 832-839)

I wondered whether repeating the word "just" for Nick was a way to convey his need for simplicity. He "just" seemed to want to be able to let go. I remember the way the word "just" echoed in my mind, evoking the concept of simplicity and ease. Perhaps beginning to get the sense of recovery allowed Nick to attune to that comforting sense of "just...", which appeared to award him a sense of freedom. Nick, seemed to cherish his rediscovered spontaneity and naturalness.

William also found a sense of liberation as he began detaching from his eating habits. He went on to explain how the sense of freedom in turn invigorated his motivation not to engage in restricting.

it was liberating so once I started eating more, so that's one motivator, a motivating factor for sure. (William: 464-467)

Wes showed an interesting analogy, comparing himself to a bird after battle.

I think in the animal kingdom sometimes you'll see the animals after they get into a fight they'll like shake out[...]their feathers and it's very sort of physical to get that off and I find people, we don't really do that, I find we just hold everything inside so I think for me it has been important sort of to have that release however you do it but yeah! (Wes: 638-646)

Wes poetically described his sense of relief in being able to disclose his experience. Although his expression entailed verbal disclosure, he likened his feeling of liberation to a physical sensation.

Daniel seemed to make sense of his recovery as an ongoing process.

I've got job stability, and I'm doing what I love and it's very similar I think with a few minor hick-ups I'm enjoying food, I have a positive relationship with food, but I don't want to stop (Daniel: 1378-1380)

He noted his professional satisfaction and his positive relationship with food, both seemed to afford him quality of life.

Edward recognised he was currently being confronted with "a huge transitional period" (538).

His considerations on what he was leaving behind, and hesitation in facing the unknown future, allowed his ambivalence to manifest.

R60: And what makes you progress on this way which is, is in contrast with what you describe as what you love?

I60: It's a good point! I honestly don't know, I don't know why I'm sticking at it. I suppose...I think I know it's going to be tough because the reason I sort of got into it is the real world is a fucking terrifying place for anyone to be and I did it for an escape; it wasn't reality, it was a story, it was a narrative and I suppose now that I know that to try and kind of fit back into that seems silly, naïve, childish, uhm... yeah it's a really good question I don't know why I'm sticking at it. And that scares me that really scares me, that really scares me. (Edward: 491-509)

Edward confessed feeling scared and unsure about the reasons that motivated him to change and move away from the AN. It seemed likely that this was a time when Edward did not feel in control of his life. Perhaps being unaccustomed to this sense of flexibility frightened him.

*I wondered whether he would feel less terrified if he could gradually find firmer ground through those things which had motivated him initially to slowly let go of his AN. I was thinking of his job, his romantic relationship, his new role as an uncle, and of the projects he had in mind.*

This chapter sought to present the analysis of the interviews with the eight participants. IPA was used to conduct the analysis of the transcripts. The first master theme was 'sense of control', which included four sub-themes: 'The "constant" worry', 'fear of failure', 'controlled awareness', and 'letting go'. The second master theme, 'me and the world' and included three sub-themes: 'romantic relationships', 'parent-son relationship', 'sense of shame and loneliness'. Lastly, the master theme, 'connecting', presented three sub-themes, 'changing awareness', 'coming clean', and 'reflections on motivation and recovery'. This chapter shows the ways their experience of motivation, in its different forms, seems to have escorted the participants through this portion of their life. The men's experiences of MoC during their journey with AN emerged as unique to each one of them, although showing some shared qualities.

## 5. Chapter Four: Discussion

This study is one of the few enquiries focusing on men's experience of AN (Darcy et al., 2012; Guegen et al., 2012). Moreover, MoC has rarely been considered in qualitative studies in relationship to this ED (Carter et al., 2014; Nordbø et al., 2008; Pauli et al., 2017; Young et al., 2018) and has more often featured in studies of women and in the EDs field in general (Casasnovas et al., 2007; Clausen et al., 2013; Kitson, 2012). To the researcher's knowledge this is the first enquiry to explore MoC in relation to AN in men.

In this chapter, before moving into a critical discussion of a variety of different aspects of the research itself, the key findings from the analysis will be considered in light of the literature already mentioned and of new literature where novel findings have emerged<sup>7</sup>.

To help the reader navigate the Discussion see *Figure 1*. (section 4.)

### 5.1. Sense of Control

#### 5.1.1. The "constant" worry

The men's voices emphasised the pervasiveness and the implacability of worry in their cognitions. However this seemed to feature in different ways across the cohort for example, two of the most commented on were:

- i) At the beginning of their journey, worry emerged as a tool and asset in controlling their AN as it permitted them to focus on its maintenance.
- ii) At a later stage their worry was perceived as exhausting and functioned as a trigger for their MoC towards recovery.

The current research supports Sassaroli and colleagues' (2005) findings on worry in EDs, which showed that worrying was linked to the experience of AN in particular. Sufferers' preoccupation with weight and shape appears in the diagnostic criteria within the DSM 5 (APA, 2013) and has been confirmed in the literature on AN (Bruch, 1978; Startup, Oldershaw, Stott, & Tchanturia 2013). The restrictive cognitive focus of worrying,

---

<sup>7</sup> Throughout this discussion section use of third person referring to the 'researcher' will be made in offering interpretations in light of the findings and existent literature. Use of the first person will be made when presenting personal reflexivity.

characterising individuals with AN, is supported by “eating-disorder specific” and “non-eating disorder specific” cognitions (Startup et al., 2013, p. 302). The present research confirms that the men’s worrying went beyond their weight and body shape, and into planning their time, daily activities such as exercise, professional life and social commitments.

The men’s experiences validate Roncero, Perpiñac, Belloch, and Treasure’s (2013) finding that EDs’ intrusive cognitions are positively correlated with AN’s egosyntonicity<sup>8</sup> for individuals and vice versa. Moreover, their accounts confirm Wells (2000) who contended that meta-cognitive beliefs (i.e., how individuals think about their thinking), in people with AN play a role in the maintenance of the disorder: for instance, when Matt said, “which may be completely insane to some[...]you just have to obey these rules”. Startup and colleagues (2012) amongst many others (Tchanturia et al., 2012; Abbate-Daga et al., 2013) stated that worry and rumination contribute to AN sufferers’ disengagement with a variety of feelings and thoughts, and to upholding psychological inflexibility and cognitive rigidity. They explained that psychological inflexibility and cognitive rigidity help in “numbing” peoples’ emotional states, facilitating the maintenance of AN. Wildes, Ringham and Marcus (2010) confirmed previous research (Treasure & Schmidt, 2006) stating that people who experience AN frequently engage in emotional and experiential avoidance attitudes through constantly worrying. The participants’ narratives appeared to support these findings, for example, when William recalled, “by doing that it [worry] gave me something to do”.

At a later time in the participants’ experiences of AN the “constant” worry was perceived as overwhelming and exhausting for some of the men. They seemed to realise that their unceasing preoccupation was hindering them from doing anything else in their life. For example, Nick said: “it just leaves you no space to do anything else[...] realising that, helped me change”. The new understanding of the men’s unrelenting worry functioned as a trigger for MoC away from their AN. However not all of them described their worry ‘helping’ their MoC; perhaps their ‘cognitive rigidity’ had not been impacted by the ‘undesirable effects’ of “constant” worry. For example Matt recalled the extensiveness of his preoccupation: “for me it’s been literally every minute of every day, if I haven’t behaved, this set of rules[...]like starve yourself for a day”. It is interesting to note that he also said, “I’m in control; but I’m also a slave.” Whilst this phrase seems to demonstrate that Matt’s perception of AN

---

<sup>8</sup> The egosyntonic nature of AN, is understood as the individuals’ valuing their disorder, “thereby hindering motivation for recovery and engagement with treatment” (Gergersten et al., 2017, p. 1).

behaviours is egosyntonic, the embedded contradiction may suggest an inner conflict and ambivalence towards AN. Ambivalence often characterises AN sufferers' cognitions (Serpell et al., 1999; Dawson et al., 2014)

The ability for some to conceptualise the “constant” worry as a factor or as a tool for MoC seemed apparent. Preoccupation has been often associated with psychological inflexibility and cognitive rigidity (Startup et al., 2013), therefore more aligned to paralysis rather than movement. It could be hypothesised that the experience of unremitting preoccupation facilitated the questioning of the AN's egosyntonicity and a movement towards change on the way to recovery. This seems in line with Gregertsen et al. (2017) who commented that “patients may desire AN so long as its advantages are perceived to outweigh its disadvantages” (p.4).

### *5.1.2. Fear of failure*

Ff characterised the men's lived experience of AN and their relationship with the ED, with most of the participants making direct references to their Ff in the interviews. It appeared to dictate the way most of them organised their lives during their experience of AN: for instance, in engaging in ED maintain behaviours, working hard to develop a career and preserving social commitments. Ff manifested in the participants' endeavours towards “victory” or “success”, and away from being “seen to fail”, and the “anxiety” of the feeling of failure, suggesting a link with perfectionism. In the current study, perfectionism did not emerge with the same frequency and intensity as Ff.

Conroy, Kaye and Fifer (2007) argued that Ff is considered to be one of the driving forces underpinning perfectionism. This link is interesting in relation to the way the participants interwove the ideas of perfectionism and Ff where a number of men reflected on considering themselves inclined towards perfectionism and always having been “driven” people. This finding might suggest that past research featuring perfectionism may have overlooked the finer experience of Ff because embedded within perfectionism.

Locating past literature on Ff related to EDs or AN was not an easy task; studies which looked at Ff focused on sports (Elison & Partridge, 2009). It seemed that perfectionism has been used as an umbrella term for Ff as well (Hurst & Zimmer-Gembeck, 2015; Sutandar-Pinnock et al., 2003). This does not come as a surprise as literature repeatedly demonstrated that perfectionistic behaviours characterise sufferers of AN (Bardone-Cone et



al., 2010; Cockell et al., 2002). The researcher's exploration of the literature base to date demonstrated that Ff in relation to AN and EDs is an under-explored area.

Ff shifted its definition for a number of men during their journey, initially failure meant not being anorexic, subsequently failure was understood as not recovering from the ED. Drawing upon the men's experiences, Ff could be understood as a 'drive'. From this perspective, AN could be conceptualised as a way of avoiding failure as the participants were initially using their Ff ('drive') to uphold their AN and later to steer themselves away from AN. The view of Ff as a 'drive' appears novel in the context of the existing AN research particularly, for men with the ED.

It is interesting to notice that the strong drive for success or the firm grasp on fear, allowed some of the men to invert and sustain their new motivational direction by channelling Ff into a recovery path from AN. However, the 'control-focused' cognitive processes featuring Ff, which had been sustaining the men's anorexic behaviours, seemed to be continued despite the new objective. The change in motivational direction seemed, nonetheless, to allow for change and physical recovery from AN, as participants managed to uphold their new goal to be healthy again. This might suggest that the change driven by their behaviour had begun to impact the cognitive rigidity and psychological inflexibility which had contributed to the inception and maintenance of AN. Based on the cognitive behavioural therapy framework (Greenberger & Padesky, 1995) where thoughts, emotions, behaviours and physical symptoms are inter-connected, individuals may change the way they think, by altering their behaviours, before modifying their thoughts and beliefs.

It seems important to reflect on Bardone-Cone and colleagues' (2010) findings which challenged the notion of recovery from EDs. The authors cautioned that some former sufferers of AN who no longer meet its physical and physiological diagnostic criteria may still be preoccupied with food intake, weight and body shape, suggesting the maintenance of "perfectionistic" thinking patterns (Bardone-Cone et al., 2010).

Similarly, the cognitive aspect of AN did not seem to cease for the men in the current study. It appeared that Ff which characterised the direction of men's MoC still involved maladaptive cognitions, for instance, Nick said: "not recovering, not being seen to recover would be worse than getting this in the first place." This seems to suggest the continuation of the participants' underlying relationship with Ff regardless of their MoC and steps towards recovery. Hence, efforts to recover were fuelled by internal "pressures to succeed", to keep in control and by external demands: They did not seem to want an audience to their failure.

Perfectionism has been conceptualised multidimensionally as having adaptive and maladaptive dimensions (Stoltz & Ashby, 2007). The researchers defined 'adaptive perfectionism' devoting efforts towards making achievements, yet accepting mistakes whilst not engaging in extreme self-criticism. The literature confirmed that generally maladaptive perfectionism involves a need to stay in control of a given situation whilst upholding extremely high expectations for oneself and being inclined to engage in harsh self-criticism (Costa, Hausenblas, Oliva, Cuzzocrea, & Larcán, 2016; Rice & Stuart, 2010; Soenens, Vansteenkiste, Luyten, Duriez, & Goossens, 2005). Engaging in extremely high expectations of oneself was observed repeatedly in the participants, for example, Nick and Wes wanted to recover and yet their drive seemed to be rooted in maladaptive cognitions: "once I got in the position of being more open to people that I had a problem and I was trying to recover, then I had to not be seen to fail" and "Am I even going to be good at recovery?". As Ff is understood as one of perfectionism's underlying forces (Conroy et al., 2007), and in comparing the existing research on perfectionism with the current findings on Ff, the researcher hypothesises a 'multidimensionality' of Ff.

#### *5.1.3. Controlled awareness*

Most of the men in the current study demonstrated awareness of their illness and its repercussions, and perception of their emotions whilst experiencing AN. In spite of their insight, the egosyntonic nature of AN contributed to directing and controlling their awareness towards upholding the ED, instead of reaching out for help from their parents, carers or professionals. The perception of their experience of AN was congruent with their values, feeding in their autonomous motivation (Deci & Ryan, 2000; Gregertsen et al., 2017). As mentioned in the Introduction, "autonomous motivation" (Carter & Kelly, 2015, p.76) or "intrinsic motivation" involve doing something because it is "inherently interesting and enjoyable" (Ryan & Deci, 2000, p.55), in contrast to when one is moved by external pressures.

William said that he felt the urge to exert control on his life and had learned that EDs could become a way of controlling (hence became "interesting") and because of this he engaged with AN. Research showed that individuals who suffer from AN may lack insight, have limited awareness of their illness, or deny their condition (Dovydaityene & Maslauskienė, 2013; Vitousek, Watson, & Wilson, 1998). In line with Serpell and colleagues' (1999) findings, the participants' experiences challenged the aforementioned studies as the men seemed to be aware of what was going on for them.

Participants did not appear blind to their AN, rather it looked like they may have not been ready to, or did not want to, see some of its effects. For instance when Matt said, “that’s as serious...it’s very lethal[...]you know a serious physical illness” and “so constantly, everyday there’s new incentives to starve myself”. Despite Matt seeming very aware of the impact of his AN, including its risks, he seemed to be ‘controlling’ his awareness. Moreover, as AN held an egosyntonic value for the men, it appeared that their insight was not translating into efforts towards trying to change or recover from the AN. For instance, Wes disclosed that he believed that looking like a “skeleton” may have encouraged others to love him. Research has confirmed that AN, for some, is viewed as a means of communication (Nordbø et al., 2006; Serpell et al., 1999); perhaps the men did not know how to communicate their needs otherwise, and having a concerning physical appearance reached their loved ones. As Dovydaityene and Maslauskienė (2013) proposed, illness representation could take an individual meaning and could possibly create contradictory motivation, not related to the illness itself.

Pollatos et al. (2008) asserted that there is a reduced perception of “interoceptive” bodily signals (physical sensations) in people with AN, possibly indicating a factor contributing to the scarce impact of the men’s awareness on change. This seemed to be in line with the empirical understanding that emotional numbness is frequent in people with EDs (Wildes et al., 2010). Edward explained that his senses were not always so active. For instance, when being offered a job opportunity he had long hoped for, he did not feel the joy he would have expected or previously experienced. Whilst this seems true for some participants, like Edward and Nick, others appeared aware and able to perceive their emotions whilst experiencing the illness. Moreover, Edward himself, other times vividly remembered physical sensations, and the emotions: “being absolutely famished and hollow and enjoying that; revelling.” and “I was light[...]physically and mentally[...]”. Edward’s experience seems to be in contrast with Bruch’s (1962) indication that sufferers’ “awareness of hunger and appetite in the ordinary sense seems to be absent” (p.189). It also seems in contrast with a wealth of literature reporting AN sufferers’ difficulties in representing, communicating and feeling emotions and diminished capacity to experience pleasure and reward (“anhedonia”) (Courty, Godart, Lalanne, & Berthoz, 2014; Wildes et al., 2010). Moreover Edward’s experience seems to highlight the egosyntonic nature of felt sensations which characterise the lived experience of AN. His vivid and poignant recall of emotions and sensations suggest that this is an area of further exploration. It could be argued that absence or fluctuations of felt senses may have implications for the maintenance of the AN. Perhaps their frequency and

intensity need to be enough to impact on autonomous motivation which would otherwise remain unaltered, hence maintaining the AN.

#### *5.1.4. Letting go*

All participants seemed to connect to the theme of 'letting go', however, not all engaged in the process of letting go of their AN. Experiences of motivating factors which facilitated the process of letting go varied across the cohort.

In reflecting on Self-Determination Theory (SDT), Vallerand (2008) argued that the autonomous internalisation of an activity into one's identity fuels passion, bringing people to engage in what they love doing. He reported that this leads to adaptive outcomes. A number of participants' experiences seemed to support Vallerand (2008) as they managed to let go of their ED through finding a passion, such as engaging in the work they most loved. These experiences appeared to help the men develop their sense of self. For example, Oscar described discovering his passion for working with horses and the way that this enabled him to feel successful and appreciated by others. Pauli et al. (2017) explained that increases in self-esteem allow people to adopt more active coping styles. In line with this, the men explained that the experience of accomplishment and feeling accepted whilst being with others helped them loosen their grip of the ED. AN's control appeared to subside as they found new goals they felt they could achieve.

Nordbø and colleagues' (2008) study expanded the concept of MoC into understanding what makes patients recover. They found that participants' awareness of health-related "negative consequences" (p.640) and acknowledgement of the "social costs" (Nordbø et al., 2008, p.635) of AN could trigger people's MoC. Nick's sense of feeling "fed-up" with his AN-related health conditions, and hiding his behaviours from others, being isolated, and worrying all the time, supported Nordbø's (2008) findings. Nick explained that these feelings triggered his MoC and helped him let go of his AN.

It is worth noting that identifying with the experiences of others helped Wes to let go of his ED. Listening to another person's recovery experience seemed to give him hope and the courage to loosen the hold and let go of his AN. Repper and Carter (2011) found that peer support interventions in MH settings positively impacted patients' engagement in treatment and their agency, empowerment and hope, amongst other variables. It seems that sense of shared experience also allowed Wes to increase his MoC.

Most existing studies focusing on individuals' ambivalence in AN have conceptualised ambivalence as an obstacle for MoC (Jenkins & Ogden, 2012; Serpell et al. 1999; Williams & Reid, 2012). At the time of the interview, Edward felt he had 'let go' of his AN and was on a recovery journey; he had restored a healthy weight and was not reporting 'disturbed attitudes' towards food and body size. In line with previous studies, Edward was able to acknowledge the advantages of letting go of his AN and this seemed to maintain his MoC and uphold his recuperation (Gregertsen et al., 2017; Jenkins & Ogden, 2012). However, Edward seemed to 'praise' the qualities of both his 'past' AN identity and his 'new' identity indicating further layers of his experience. The literature on men's experiences of letting go or the recovery processes in AN and identity, appear scarce and under-explored. However, Pettersen et al. (2013, p.98) in conducting a study with women with EDs, acknowledged that "searching for identity" and "accepting losses" characterised the "later phases" of the recovery process. Furthermore, Lamoureaux and Botorff (2005), in their study on women in recovery from AN, affirmed that understanding the process of recovery can support sufferers in maintaining their efforts. Reconstructing a sense of identity is viewed as part of the process of recovery (Lamoureaux & Botorff, 2005; Pettersen et al., 2013). The researcher argues that this process can be critical in maintaining MoC, facilitating the process of letting go, and 'completing' the recovery path.

The men's narratives appeared to point towards the importance that those around the sufferer should follow their idiosyncratic disposition in supporting their MoC on their recovery journey. This supports the view that those around the sufferer, such as families, services and therapists, may facilitate a man's process of letting go of AN by attuning to the individual personal experience (Vitousek et al., 1998). This theme also validated the relevance of autonomous MoC in helping practitioners understand and assess individual readiness to act on change (Thaler et al., 2016). Finding personal incentives for change enabled the men to change direction in their journey with AN and may be of benefit to others.

## **5.2. Me and the world**

### *5.2.1. Romantic relationships*

The current study found that the majority of the men were involved in long-term heterosexual romantic relationships during their experience of AN (p.131 *Discussion on sexuality norms in EDs*)

*I was intrigued by the participants' ability to get involved in long-term romantic relationships. I wondered how does the tendency towards isolation in the participants and in people with AN reconcile with the engagement in committed relationships?*

Research conducted with women with AN has shown relationships' lack of intimacy and the participants' struggles with emotional and physical closeness (Arcelus et al., 2012). Although only one participant in the present enquiry talked about his sexual drive, he referred to its increase since changing and recovering from AN. The participant's disclosure seemed to lend support to previous studies asserting that males with AN lose sexual drive (Wooldridge & Lytle, 2012). His disclosure seemed to align itself with previous enquiries showing that individuals with AN display emotional avoidance, including avoiding "experiencing or expressing physical sensations, thoughts, urges, and behaviours related to intense emotional states" (Wildes et al., 2010, p.398). These sensations generally characterise romantic relationships. The researcher acknowledges that Edward's revelation illuminates an area to which the other participants do not make reference, however aspects of physical and emotional involvement in romantic relationships may have relevance in experiences of MoC. Hence, Edward's narrative seemed worth noting and raises questions regarding the definitions, dynamics, qualities and values upon which romantic relationships during AN are based.

Fischer and colleagues' (2015) study on couples with female sufferers demonstrated that "questioning and criticizing" were considered unhelpful by individuals experiencing AN. Participants in the current research reported that not being challenged, and feeling validated by their partners, made them feel at ease, and did not prompt hiding behaviours, supporting Fischer and colleagues' (2015) findings. The men described their couple-interactions as the only relationships in which they felt safe in discussing and performing their routines, and showing their vulnerabilities. This might suggest that being around their loved one triggered a sense of acceptance, self-care and self-respect which manifested in their improved eating behaviours. Espell, Goldstein, Manasse and Juarascio (2016) contended that self-acceptance is positively linked to MoC. This appears to be confirmed by the participants in the current study, when describing being more likely to eat larger quantities of food, of better quality, when with their partners. Matt said that he would just "slip" into his girlfriend's "eating pattern" when spending time with her. Løvoll, Røysamb, Vittersø and Zourbanos (2017) in their study on the effects of positive emotions on intrinsic motivation, explained that positive emotions can trigger new directions for motivational interest and change behaviour by helping us prioritise amongst multiple motivations. In the current study, the women's behaviours seemed to mediate their partners' (sufferers') honesty and openness with

validating and not challenging attitudes. Furthermore, the present research seems to corroborate past enquiries that partners are considered helpful when providing emotional support and when communicating (Zac-Hunter & Johnson, 2015). It also appears to lend support to Tozzi and colleagues (2003) who conducted a study on recovery from AN where “supportive partners” were rated as the most important recovery factor amongst other sixteen factors. This study therefore backs Fischer and colleagues’ (2015) investigation which found that accepting and validating behaviours in partners facilitated motivation in the direction of recovery.

Whereas this study and previous findings showed that ED sufferers may view their partners as being very supportive and important in their experience of AN, their partners may have a different experience (Fischer et al., 2015). Fischer et al. (2015) interestingly noted that the partners of female sufferers who reported the least “distress” were encouraging changes to AN behaviours in their female partners and the opposite was experienced by those who showed more patience and understanding. This seems to indicate an incongruence of perceptions and, feelings within couples, and may have implications in the long-term for the partners well-being and for the quality of the couple’s relationship and the support provided. Empathy may come with a great cost for the relationship’s duration, quality, and for the partner’s well-being. The experience of romantic relationships for couples where men are experiencing or have experienced AN, the inter- and intra-personal dynamics, is a research topic which appears to be under-explored.

*I considered the nature of their partners’ acceptance. Is it not distressing to watch a loved one harm themselves and cause visible damage to their health? I wondered what would have the girlfriends felt or interjected if they had heard or had been present during the interview. Bulik, Baucom and Kirby (2012) reported that partners present emotional responses such as anger, grief, shame, anxiety, depression and guilt. I also wondered whether the partners’ non-interference had always been perceived as helpful. Could the non-interference and sense of acceptance also be perceived as synonymous with lacking consideration for their health?*

*Additionally, I was intrigued by the absence of remarks regarding fear that these relationships could end. This was only voiced by Liam.*

Liam and Daniel disclosed having been involved in relationships that had ended during their experience of the illness; they said that their former partners made them feel uncomfortable and not accepted. This supports previous findings showing that relationships were, in some cases, detrimental, intensifying shame and ED behaviours (Sanchez & Kwang, 2007). Their

experiences aligned with Zak-Hunter and Johnson (2015) who contended that ED symptoms are exacerbated when sufferers' perception of emotional or physical distancing increases. This suggests the magnitude and depth of romantic relationships' impact on men's relationship with their ED.

Moreover, Liam revealed feeling urged to change for his present girlfriend: "I do it for my girlfriend's benefit[...]". From this statement it seems that he was moved by extrinsic motivation, supporting previous literature maintaining that individuals discriminate between intrinsic and extrinsic goals (Deci & Ryan, 2000; McLachlan & Hagger 2011). However, his girlfriend was not imposing certain behaviours, allowing him to be unguarded, and comfortable in showing his vulnerabilities. Perhaps then he may also have been afraid to lose her, as in the past he had lost a girlfriend to his AN. These reflections may lead to the consideration of whether Liam's motivation had an intrinsic nature too, as it was his "interest" not to lose her. The possible combination of intrinsic and extrinsic factors of MoC seems under-explored in EDs, particularly in men with AN.

#### *Discussion on sexuality norms in EDs*

A number of studies have looked at the sexuality of men with EDs (Feldman & Myer, 2007; Robinson et al., 2012). Fichter and Daser (1987) reported that the amount of gay males in the ED population is double compared to gay men in the general population. Results to date however appear inconsistent (Chung & Bravender, 2011; Peate, 2011). The current study found that the majority of the men were involved in long-term heterosexual romantic relationships during their experience of AN. Only one participant who was single declared his homosexuality. The other seven did not declare their sexuality, however six of them had engaged in committed heterosexual relationships either during or after their experience of AN. This finding seems important in disconfirming the widespread assumption mentioned in the introduction that men with EDs are homosexual (Cuban, 2013; Thomas, 2013). AN like other EDs does not seem to discriminate. Perhaps the female-focused research in EDs might be leading to a false assumptions that AN is a female illness, and when presenting in men it only presents in homosexuals. It is important not to be blinded by male's sexuality when thinking about males' experiences of EDs.

#### *5.2.2. Parent-son relationship*



The importance of families in the recovery process of AN is well-documented (p. 25, *Relationships*). The instrumental role of parents' understanding of AN in their sons' journeys emerged from the interviews in the current study.

The men's interpretation of their parents' understanding of their AN and involvement in their experiences seemed to have had different implications for the participants' relationship with their ED. Moreover these phenomena varied across participants' experiences.

For instance, Nick and Liam's parents did not take part in their son's experiences of AN. However, the men reacted in a very different way to what they interpreted as non-involvement. Nick's wish to recover and his need to involve his parents was not hindered despite their lack of proactivity. His MoC helped him to challenge their attitude by initiating a conversation with them. On the other hand, Liam's path with AN appeared to be somewhat mirroring that of his parents. He felt they "turned a blind eye" and unlike Nick he had not confronted his difficulties with them. The present study supports Le Grange and colleagues' (2009) observation that "no structure or pattern" could be identified to mark the ways families with ED sufferers functioned, as the ED may develop and be maintained in varying family contexts.

Intrinsic motivation is developed through positive emotions (Løvoll et al., 2017). For Liam, experiencing being given up on seemed to hamper his development of a strong sense of self. This appeared to have repercussions on his MoC and seemed in line with Pauli and colleagues' (2017) claim that maladaptive coping strategies may predict ED (Villa et al., 2009) and are related to lower motivation to overcome the disease.

It is interesting to conceptualise the dynamics illustrated above with systemic "complimentary" and "symmetrical" ways of communicating (Watzlawick, Beavin, & Jackson, 1967). Nick's dynamic appeared as "healthy" and "complimentary", meaning he responded to give a message or "correct" his parents. Liam responded in a similar way to his parents, hence his feedback was "symmetrical". However, the dynamic between Liam and his parents can be considered unhealthy as it seemed to feed into Liam's self-destructive behaviour.

For some participants, their parents' engagement was key to recovery. In particular, mothers seemed to be the main source of support for some and when mentioned, relationships with fathers were portrayed as conflictual. Le Grange, Host, Locke and Bryson (2011) conducted a study on emotional expression with young women with AN and found that parental warmth

predicted positive treatment outcome rates. In this study, the men who reported their families' support throughout their experience of AN explained that their encouragement gradually enabled them to get closer to the idea of recovery. This progressive acceptance of being supported allowed them to eventually find their own agency, MoC and way towards recovery. For example, Wes explained that his family showed him support and encouragement and reminded him daily of his need to act on the problem. This seems to indicate that warmth, presence and tenacity on behalf of their family nurtured the participants' drive towards change, and their intrinsic MoC.

### *A novel take on the role of the family*

A fascinating juxtaposition to the research literature could be noticed wherein often times parent-child relationships in the ED context are portrayed as conflictual and having an influence on AN onset and maintenance, and a detrimental effect on recovery processes (Eisler & Le Grange, 2008; Latzer, Hochdorf, Bachar, & Canetti, 2002). Some of the participants who spoke about their parents' involvement valued it. In particular, they described their mothers as having vital roles. Previous studies accounting for conflictual or complex relationships are generally based on the mother-daughter dyad, for instance Langenbach and Subic-Wrana (2009) psychoanalytically illustrated the female identification problems due to unresolved conflicts with maternal representations. Hill and Franklin (1998) encouraged consideration of the complexity of the relationship whilst accounting for the maternal role in the transmission of cultural value and physical appearance.

In an enquiry conducted in 1998 by King, fathers' critical comments, combined with daughters' hostility and lack of cooperation aggravated both fathers' and children's attitudes over time, suggesting implications for a lack of MoC. This finding was confirmed by May, Kim, McHale and Crouter (2006), who indicated that conflict with fathers correlated with both sons' and daughters preoccupation with weight gain. In the present study the men who explicitly spoke about their interactions with their fathers conveyed a sense of conflict and lack of understanding. Moreover, at the time of the interview, Matt and Liam were both still experiencing the symptoms of AN and reported ongoing conflictual relationships with their fathers, possibly confirming the aforementioned studies. These findings suggest repercussions on their sons' sense of self and for their MoC. On the other hand, as mentioned, mothers were portrayed as being key in their journey of recovery. This raises questions as to whether gender identification may play a part in their experience of AN. Miller (2011) looked at fatherhood in the UK from a social constructivist point of view. Her findings showed that men have more power in choosing the extent to which, and the

modalities with which, they involve themselves in childcare and that fatherhood seems to be still based on power differential between genders. It might be interesting to consider whether the relationships between the participants in the current study and their fathers lacked common ground or intersection points which would enable fathers to identify themselves and feel closer to their sons, therefore having consequences on their sons' MoC.

*I wondered whether either of their parents would have acted differently had they been females with AN. I also was struck by the fact that the parents' relationship was not mentioned by any of the participants. Lavee, Latzer and Gal (2009), reported that women with AN described conflict between their mother and father, suggesting that such interactions impact ED behaviours of the individual. Moreover, I was curious about the absence of other family members, including siblings, on the men's journey in their narratives.*

#### *Parent-son, peer relationships and gender norms*

Gender roles' importance appeared to manifest within William's parents' attitudes towards their son's difficulties, and seemed to be reflected in his beliefs around masculinity. It seems relevant to note William's interpretation of his parents' and peers' beliefs in relation to his conceptualisation of masculinity and MoC.

William seemed to perceive his parents' and peers' beliefs as a threat to his masculinity. This led him to "give up" his AN, and to channel his energies onto a solitary recovery path. As mentioned in the Introduction, help-seeking and manifesting vulnerability not reconcile with masculinity ideals (Räsänen & Hunt, 2014). William's decision not to seek external help is in line with Petrie and McFarland's (2009) findings that the societal prejudice associating EDs with females' illnesses induces men not to seek help. William's drive for recovery seemed spurred by his sense of shame in not having adhered to socially constructed ideas of masculinity, and consequent apprehension of being rejected by his parents and peers. Admitting his ED to his parents or his friends may have signalled vulnerability, hence contradicting his sense of masculinity. According to Nordbø et al. (2012), one of the core obstacles to motivation in individuals with AN, is the "perceived judgments" or opinions expressed or unexpressed by those around them. This study seems to challenge Nordbø et al. (2012) as William appeared to be prompted to change upon learning of others' opinions of him. It seemed that William, despite not seeking anyone's help, managed his shame by choosing to recover, albeit alone. He did not engage in more dangerous "over-compensating" behaviours, such as avoidance, or attack on the self or other (Willer et al., 2013) to prove his masculinity.

*Although the impact of masculinity on the men's experiences of AN did not come out in other accounts, there is something that seems important here and worthy of further investigation. When thinking about the ways the men experienced their motivation, I could not help remembering what support I found helpful during my own ED experience. I valued others' love, care, and empathy, although I remember being mistrustful of others' understanding. I greatly appreciated challenging conversations, however I remember only believing in a few people's ability to support me. I was critical towards others' ways of making sense of my difficulties, perhaps echoing my own self-critical voice. Although words and conversations were important in gradually chipping open a path towards recovery and increasing my MoC, changing cognitions alone was not 'convincing' enough for my AN to subside. I recall that with every slight change I would bring to my routines, I allowed myself to accrue a greater sense of safety and confidence that control would not go out of my hands. This gradual build-up helped me feel more confident and in turn enhanced my MoC. As I was enjoying things that I had deprived myself of, I managed to slowly let go of the illness. For me behavioural changes were fundamental, however perhaps I only managed to act on these because of the supportive encouragement from others. Waller (2011) suggested that motivation could be treated as a behavioural phenomenon in therapy when individuals are stuck, when there are no shifts despite readiness to change. From my own experience and those of this study's participants I wonder whether the efforts should be a combination of behaviour change and supportive encouragement.*

### *5.2.3. Sense of shame and loneliness*

The men's sense of shame and loneliness shaped the way they felt and how they related to the outside world. Their perception of the negative judgements of others fuelled their sense of shame and reinforced their own self-judgment, leading them to isolate. Moreover, these emotions seemed to impact on their MoC in different ways across participants. Research has shown that loneliness and shame characterise people's lived experience of AN (Ali et al., 2016; Rance et al., 2017; Räisänen & Hunt, 2014). The current study lends support to these findings as these feelings featured prominently in the participants' experiences.

Skårderud (2007) observed that shame can be experienced both as cause and consequence of AN, giving rise to a "shame-shame cycle". This seemed to be the case for participants in the current study too. Shame emerged as internal (negative self-evaluation) and external ("feeling others look down on them") (Goss & Gilbert, 2002; Skårderud, 2007, p.83). Internal and external shame were precursors and perpetuators of the AN when

participants' embarrassment stemmed from feeling physically inadequate. This sense drove participants to isolate, and loneliness emerged as a further consequence of shame. For example, Daniel did not accept his bodily appearance and felt uncomfortable in locker rooms at school. His experience of bodily shame echoed previous studies on AN in men and women (Troop & Redshaw, 2012). Olivardia, Pope, and Hudson (2000) described similar behaviours in men with muscle dysmorphia as a consequence of bodily shame, confirming, as mentioned in the Introduction, the possibility of comorbidities in ED presentations and sufferers' overlapping and shifting between EDs. For Daniel shame was a precursor and perpetuator to isolation and loneliness in AN, as captured by Skårderud (2007), therefore possibly being conceptualised as a risk factor for AN.

### *Shame and masculinity*

Studies showed the way shame was a consequence of AN for male and female sufferers as they felt embarrassed by their ED (Murakami, Essayli, & Latner, 2016; Griffiths et al., 2014). The current study validates these findings and shows that the participants' sense of shame motivated them towards isolation from those around them. This research further corroborated that men may experience a double-stigma (Strother et al., 2012). "Having a diagnosis" and "belonging to a stigmatised group" (Skårgerud, 2007, p.91), which may be perceived as discriminating for both men and women (Griffiths et al., 2014; Murakami, et al., 2016), is further intensified by AN's female-only connotation. In William's experience for instance, his sense of "embarrassment" in having a disorder which was associated with females, undermined his masculinity and led him to seek isolation. His experience seemed to be supported by the belief that men should be "independent, self-reliant, strong, robust" (Courtenay, 2000, p.1387). William's experience invites us to consider a novel perspective of shame and sense of loneliness as tools for recovery: it could be argued that these emotions prompted William's MoC. Not only did this lead him to feel lonely, not asking for family support or professional help in trying to elude his shame, but they seemed to trigger other cognitions and behaviours, such as MoC, engaging in a recovery process.

On the other hand, although not overtly expressed, Liam seemed to be pursuing stricter adherence with certain masculine precepts such as successful career and an active social life. He spoke about not being able to initiate change regarding his AN and consequently acting on other areas of his life.

*I wondered whether Liam believed that his AN was not being accepted because he was a male.*

Liam's experience seems in line with Charmaz's (1995) finding whereby participants attempted to uphold their masculinity by engaging in other activities, hiding their illnesses to prove themselves to others. Liam's experience lends support to the literature reporting that embarrassment and shame may act as barriers for MoC, help seeking and ultimately recovery and that negative emotions hamper MoC (Løvoll et al., 2017).

However, for others such as William, it could be argued that these negative feelings helped in challenging the egosyntonicity of AN. Their undesirability seemed enough for their intrinsic motivation to be triggered and to change direction, prioritising a recovery path. This supports findings of Nordbø et al. (2008) maintaining that negative consequences of AN, such as social costs, trigger the wish to recover in females with AN.

### **5.3. Connecting**

#### *5.3.1. Changing awareness*

The participants' awareness appeared to change during their journey of AN. Their cognisance around the physical, mental, and emotional consequences of AN seemed to be impacting on the egosyntonicity of the illness as their journey progressed.

Gregertsen and colleagues (2017) defined the egosyntonic nature of AN as an impediment for recovery, leading the researcher to question whether the changing awareness was a factor enabling participants to connect to their sense of identity and value system. Or was it the journey of AN allowing them to make shifts in their sense of identity and to value their awareness differently? Some of the men described not recognising themselves and being alarmed by the way they reacted (or not) to certain situations. This suggests that the men's sense of identity changed over time, confirming research (Oyserman & Destin, 2010).

The identity-based motivation model (Oyserman & Destin, 2010) may help in understanding the men's reactions to the perceived incongruence between AN and their identity. This model assumes that "identities are dynamically constructed in context" and thus that individuals are drawn to engaging in situations and actions which are congruent with their identities.

Another fascinating lens through which to observe the men's changing awareness in relation to MoC is their 'value system'. A recent enquiry conducted by Mulkerrin, Bamford and

Serpell (2016) conceptualised AN as a “saboteur of values”, as seen in the current study whereby the men mentioned their fear of continuing to live a life without enjoying emotions. These findings also lend support to Nordbø and colleagues’ (2008) research which argued that the sufferers’ realisation of negative consequences, fuelled their wish to recover. Moreover their study also appeared to be the closest to the participants’ concern about the effect of AN on future generations. In the current study, Edward explained that becoming an uncle prompted him to change. The participants’ experiences and new responsibilities seemed to change their awareness on AN and enabled reconsideration of values and priorities.

In the current study not all participants’ insight and awareness managed to penetrate and impact on their MoC. A disconnect between awareness and readiness to change underpinned Matt and Liam’s ambivalence towards change: Being aware of their need to change, wishing to change, yet not feeling ready or willing to let go (Kitson, 2012; Nordbø et al., 2008). For example Liam described realising “hitting rock bottom” when dropping out of education, losing friendships, and his romantic relationship, however it seemed that in spite of the intensity of the experiences these did not match his readiness to change, leaving him conflicted in relation to his motivation. This seems to be in line with Kolnes (2016) on physical exercise experience in AN. He acknowledged that in spite of strong insight regarding the negative repercussions on health, women did not interrupt their relentless cycle of “rigorous and excessive exercise” (p.10). The egosyntonic character of AN seemed still aligned with the men’s fear of letting go despite having developed a considerable awareness of their AN.

### *5.3.2. Coming clean*

‘Coming clean’ is understood as the participants’ process of rediscovery, acceptance of the self and exposure of their experiences to others.

The men described the way they isolated in the past, hiding behaviours, thoughts and feelings, and how this fed into further alienation and loneliness. Their openness and urge for honesty was juxtaposed against their history. Their disclosures seemed to serve multiple purposes, such as, a fulfilment of their need for commonality and shared experience which had been missing in their personal journey, and their motivation and inspiration to help those who were struggling, offering their solidarity and encouragement. Most of the participants’ present attitudes seemed in sharp contrast to how they had conducted their lives during their journey with the ED and to how they had experienced AN until then.

Addressing emotions and demonstrating interest and curiosity about one's own affect seems to denote self-care as it is part of understanding and developing oneself (Hope et al., 2011). Hope and colleagues (2011) indicated that the process of self-inquiry is fundamental to understanding one's own MoC and "important in trying to develop toward a life free from the grip of anorexia nervosa" (p.27). The participants' path of 'coming clean' also seemed to validate Hope and colleagues' (2011) proposition that in AN "judging oneself primarily on the characteristics of the authentic self may help people to develop or maintain a level of self-esteem that is conducive to change" (p.27). It could be argued that this self-judgement, although not unconditional, seemed to entail adaptive qualities as it was directed towards becoming healthy, feeling a sense of belonging, increasing self-esteem, and based on the will to be honest with the self and others.

Crocker and Knight (2005) examined self-esteem as a contingency of self-worth. They conceptualised self-esteem based on people's belief of "what they need to be" and "what they need to do" (p.200) to have worth. Participants revealed the significance of connecting with their vulnerability, confronting their feelings, and exposing their experiences of AN. For some of the men it was important to become congruent with their sense of self, hence being honest with themselves and with others. Developing insight of their experience, learning about their feelings, and accepting their emotions, and changes were processes that had been key in their journey with AN. For example, Wes, disclosed believing having changed and feeling invested in his process of "reinventing" himself, suggesting a sense of curiosity for the self and self-acceptance. For most it also was important to disclose their experience to raise awareness of men's struggles with EDs and to help other sufferers, spreading a sense of commonality. For example, Daniel explained that this process made him "feel good about it".

Crocker and Knight (2005) proposed that contingencies are areas of psychological vulnerability and sources of motivation. The men's relationships with these contingencies, such as being able to talk about feelings and being true to oneself, seemed to concur with the researchers' views. For instance, their contingencies appeared to counter their vulnerability of keeping hidden and of not knowing how to address and manage emotions. Nick and William confirmed this when stating "it's trying to have less split between them..." "and since I can talk about something as serious as that, I can talk about most things". Being loyal to themselves and with others seemed to be empowering for the men whilst fuelling their drive to change. Their beliefs about what they felt they "needed to be" and "needed to



do” (Crocker & Knight, 2005, p.200) were fuelling their MoC, for example, when Daniel said, “You can get through this!...so I was trying to be that kind of person”.

In finding a way to explore, process and accept their experience of AN and publicly disclosing their experiences, the men may have developed a means to foster their self-worth through self-esteem. In line with Crocker and Knight, as mentioned above, their increased self-esteem seemed to serve as a ‘perpetuator’ of their MoC. It is hypothesised that the feelings of self-esteem which ensued from the experience of self-acceptance and achievement of authenticity in the world directed the men further away from the egosyntonicity of their AN.

It is important to note that for some participants, such as Matt and Liam, honesty and attempts of openness with others did not increase MoC nor did they impact positively on their self-esteem. Their efforts had not been received and managed in ways that encouraged them. Therefore the men’s experiences seemed to challenge the research findings mentioned above, whereby contingencies aimed at increasing one’s self-esteem are a source MoC when fuelled by self-disclosure (Crocker & Knight, 2005). Instead these participants’ experiences invite us to acknowledge the significance of the network system surrounding them, thus the role of people on the receiving end of the sufferers efforts to ‘come clean’.

### *5.3.3. Reflections on motivation and recovery*

Most participants’ responses validated Dawson and colleagues (2014) study on recovery from chronic AN, agreeing that their recovery process was complex, and ongoing, with key factors impacting on their MoC. However, the men’s sensations and experiences of MoC varied greatly across the cohort, lending support to Nordbø and colleagues’ (2008) research whereby wish to recover and MoC differed across their female participants.

Ambivalence regarding recovery emerged and was manifested in MoC, corroborating previous enquiries (Mander et al., 2013). For instance, Liam said: “I’m motivated to get better, but I’m not”. His conflicting thoughts point at his un-readiness for recovery and suggest his lack of intrinsic MoC.

On the other hand, other participants had specific reasons motivating their change and in continuing their, albeit arduous, journey of recovery. For example, experiences of liberation and spontaneity, reclamation of the self and the curiosity for the future encouraged men’s

MoC further and to challenge moments of uncertainty (Duncan, Sebar & Lee, 2015). Nick said: “being able to feel liberated[...]being spontaneous around food.” This seems to confirm Nordbø and colleagues’ (2008) study in which the ability to be spontaneous informed women’s motivations to recover. In the present research, the men managed to identify what they missed in their life experiences and to understand the things which were really important to them. Besides triggering their MoC, this realisation seemed to help them in maintaining their drive when more difficult situations manifested, and, as Nick explained, in finding “new motivations”.

It follows that acting on behavioural change could be understood as an opportunity to increase intrinsic MoC. In allowing themselves to experience things that they had previously missed during their AN, the men felt further supported to strengthen and maintain their MoC. However, this had been only possible when as Nick said, recovery “meant the lesser of two evils” therefore when AN slowly lost its egosyntonic appeal.

It is striking to notice that in their final reflections on MoC and recovery the men did not mention their parents, partners, professionals or other kinds of support. It seems important to stress that their reflections did not deny the invaluable support they had received or were still being offered. Nevertheless, their thoughts may show an implicit understanding of recovery as an intimate journey of the self. The men were relying on themselves, on their resources and skills. For instance, Wes explained using “self-talk” to support his motivation and hope when these recoiled. Miller and Rollnick (2002) argued that people are “more persuaded by what they hear themselves say than by what other people tell them.” Wes’s experience validated the importance of fostering the development of autonomous MoC and self-efficacy (Carter & Kelly, 2015; Dawson et al., 2014). This individual journey signals and confirms that a sturdy intrinsic motivation (Deci & Ryan, 2000) plays a pivotal role in fuelling the laborious and unrelenting recovery process from AN.

*I wondered whether the men were not including others in their final thoughts as they wanted to reclaim their masculinity and their ability to make it on their own?*

*Oscar did not reveal having struggled in his recovery and did not describe his motivation in depth. Perhaps, being the eldest of the interviewees he had accrued more time to reflect on his experience and to integrate it within his identity, letting go of some of the stronger memories or emotions. I also thought that, English remained a language which he may have never used to think and talk about this experience. This may have indirectly informed his choice of what to talk about, as some topics may have been more accessible than others.*

*When listening to the all the men's stories, particularly to Oscar and Edward's commitment in their roles of father and uncle, I wondered how and whether their families of origin had changed. I questioned whether they felt they needed something from their families of origin to create their family units. What did it mean for them to be parented and to parent, or in Edward's case to invest in his new role of uncle?*

#### **5.4. Reflections on the Use of IPA and on the Research Design**

This study explored the experiences of eight men's MoC in relation to their journey with AN. IPA was selected to give voice to the individuals, allowing their subjective experiences to emerge. In line with IPA's idiographic quality, the objective was not to make generalisations about the AN male population. Through the hermeneutic character of IPA, this study offers insight into the phenomenon. It expands and combines participants' subjective experiences with the researcher's interpretations of these. Consequently, other researchers may have generated different results and interpretations.

Aiming to adhere to IPA's criterion for homogenous samples, this study included English speaking men with AN, who presented with a BMI above or equal to 17.5. Due to time constraints and anticipated challenges within the recruitment process, this study did not apply stringent parameters regarding ethnicity, age, nor did it base recruitment on AN's onset or duration. Moreover, this study was conducted using two interview modalities: face-to-face interviews and Skype video calls. Language, experience of AN and BMI criteria were prioritised to uphold data quality and participants' safety. Greater time being available may have permitted tighter sampling parameters, increasing the cohort's homogeneity. It is argued however, that this sample provided a range of perspectives. This may contribute to the transferability of the findings for clinicians and researchers, which is valuable in an exploratory study. It seems important to note that the concept of homogeneity can be criticised for ambiguity. Regardless of the rigour in applying criteria to recruitment process, people's uniqueness will always emerge through their idiosyncrasies.

In accordance with Smith and colleagues' (2009) recommendations for conducting doctoral research using IPA, a sample of eight participants was considered appropriate. This sample size permitted the researcher to make best use of financial and time resources in interviewing and conducting in-depth analysis of the participants' accounts. In keeping with qualitative approaches and IPA specifically (Willig, 2013), this sample size also enabled the exploration of divergences and convergences across participants' experiences.

Although at times embedded in the men's accounts, the issue of masculinity was not extensively or directly addressed by the men, except in William's case (*Shame and masculinity*, p. 137). In keeping with IPA and semi-structured interviewing, the researcher intended to follow the participants' lead and refrained from forcing the disclosure of matters which did not expressly emerge. The interview schedule allowed the men to explore and reveal the experiences they chose to share. Deeper exploration of their relationships with masculinity may have drawn from knowledge the researcher had acquired from the literature or from her pre-assumptions. The researcher therefore refrained from directing narratives towards avenues which participants did not voluntarily take or explore in greater detail.

As mentioned, in line with the premise of IPA, the discussion of the analysis also intended to give voice to the men's understanding of their experiences. This chapter did not aim to provide reasons behind the men's experiences. Hence, these explorations provide multiple avenues from which future enquiries can depart.

## **5.5. Personal Reflections**

*As mentioned in the Methodology chapter, I endeavored to interweave my personal reflexivity throughout this thesis in line with phenomenological research precepts. In addition to the dedicated section in the Methodology chapter, I aim here to conclude with an overview on how engaging in reflexivity allowed me to develop as a first-time researcher and practitioner, whilst conducting this study.*

*Adopting a reflexive stance is advised in encouraging awareness around motivations and pre-assumptions which could taint the research process. Therefore, engaging in reflexivity helps the researcher's awareness of those incidents which might impact upon research progress (Finlay, 2003). I kept a reflective journal throughout the research process intending to remain sensitive to subjectivity, whilst staying true to the participants' stories. This also helped me to record my feelings and thoughts consistently. I used the journal to record particular attitudes I adopted towards the writing process as well, as I noticed that these could considerably change, depending on the topics I was addressing.*

*Although invested in reflexivity throughout this journey, I have found it tricky at times to discern my opinions and pre-understandings from what seemed to emerge from the participants' experiences. Taking breaks between each interview and piece of analysis, and discussing my process and the content of the interviews with my supervisor, assisted me in*

*gaining clarity and awareness of the dynamics which were ensuing.*

*Writing a reflexive journal enabled me to take a bird's eye view on the way I conducted all areas, including the discussion. I recognised that here, I was experiencing a tension: Whilst aiming to discuss the findings in consideration of the research base, I wanted to honour the individual voices of the men. These narratives made sense of the men's emotions, relationships and various aspects of their lives in ways which did not resemble one another. I wondered whether my hesitancy in summarising their understandings was linked to the importance of considering idiosyncrasies in participants' accounts when conducting IPA and practicing therapeutically. Moreover, remaining faithful to participants' experiences is in keeping with the principles of credibility and authenticity in conducting research. Moreover, whilst writing the Analysis and Discussion, I recognised IPA concepts of convergence and divergence (Smith et al., 2011) amongst the men although allowing patterns to emerge, I specifically highlighted 'outliers' to challenge 'socially constructed' assumptions and to emphasise the uniqueness of these experiences. I was mindful of the significance of CPs' tailoring treatment and care to each individual depending on their needs and goals, alongside the families', carers', and professionals' outlook on presenting problems. It seemed that using IPA produced a picture of the diversity of experiences within a small cohort of men, who travelled on journeys with AN.*

*Moreover, as mentioned, I wondered how the participants approached our encounters, and how their attitude towards their taking part may have influenced what they revealed: Perhaps a more experienced researcher would have approached the participants differently, this might have impacted their willingness to be open or the content of their narratives.*

*The reflexive exercises I implemented in conducting this research became a part of how I engage in my clinical work as well. I engage in self-enquiry by writing personal reflections on how I approach clients' assessments, formulations and develop treatment plans. Reflecting on the ways my practice is informed helps me in keeping the client at the heart of my work and in sustaining my endeavour towards providing excellent care.*

*Lastly, as a result of doing this research, when I work with men and women alike, I notice that my level of awareness around the individuals' uniqueness is notably heightened. I observe the way pre-assumptions, previous knowledge, and personal experiences, may potentially contaminate the foundation of our therapeutic relationship and mar the effectiveness of our work together. I try to stay cognisant, whilst present to the dynamics and content within the therapy room, using a journal and supervision to reflect upon these.*

## 5.6. Clinical Implications for Counselling Psychology

This study captured the men's desire to engage in reflective thought, expression, and dialogue. This emerged through their willingness to explore experiences for their own personal development, to share these with other sufferers, as well as to increase general awareness around men's experiences of AN. The findings have implications for CPs' clinical practice and demonstrate their transferability. Furthermore, in a context of austerity, it is the duty of CPs to draw on knowledge to "inform practice and be able to promote awareness of actual and potential contribution of psychological services" (HCPC, 2015, p.23). Spivak and Willig (2010) indicated that listening to individuals' needs and recommendations can be critical to improving clinical practice and treatment provision. Co-creating meaning in a safe setting such as the therapeutic relationship with a CP, can empower clients and engender a sense of agency (Rennie, 1994). These elements are necessary for fostering clients' autonomous motivation and to bring about change (Tveiten & Knusten, 2011).

Analysis and Discussion of the resultant themes highlight the different ways participants made sense of and experienced their journeys, and utilised their awareness. The research themes allow the reader to observe the unique ways the men may have made sense of and lived their experiences. This shows the importance of CPs regarding each clinical case in its individuality and holding an open, flexible mind in terms of what may be needed to help the AN sufferer.

What follows are suggestions for CPs when working with men with AN. These suggestions emerge from the master themes previously discussed, hence for clarity each master theme will be addressed in turn. These recommendations are to be considered in light of psychological formulations developed through the collaborative understanding between client and CP; this includes elucidating the person's presenting problems, needs and goals. As psychologists we must, "critically reflect on [our] practice and consider alternative ways of working" (HCPC, 2015, p.12). Therefore, this study suggests CPs adopt an integrative stance when treating men with AN.

### 5.6.1. *Sense of control*

Psychological inflexibility is one of the characteristics of people who experience AN and other EDs (Tchanturia et al., 2012). As noted in the Discussion, at times, change seemed initially driven by maladaptive cognitions associated with Ff and perfectionism. It is advised

that CPs draw upon the change initiated by the patient through coming to therapy, to create an impact on this psychological inflexibility and cognitive rigidity. Changes may create an opening in cognitive rigidities and initiate a gradual movement towards letting go of the AN. Vitousek et al. (1998) stressed the socratic method's suitability to enhance MoC in EDs. This appears critical in parallel to the findings on autonomous or intrinsic motivation and effective treatment outcome (Deci & Ryan, 2000; Treasure et al., 1999), whereby the successful treatment of patients' with EDs was related to the 'quality', or source of their drive. Moreover, following the clients' lead encourages the foundation of a therapeutic relationship based on collaboration and respect. This alliance is at the heart of the CP psychology ethos (Douglas et al., 2016) and it helps to prevent treatment drop-out rates (Mander et al., 2013; Rance et al., 2017). This finding is also in line with Miller and Carroll (2012) who pointed out that the quality of the relationship can predict treatment outcomes in AN.

#### *5.6.2. Me and the world*

In the current study's findings, parents' and partners' involvement emerged as crucial in men's ability to engage with their motivation. Treasure et al. (2005) outlined guidelines for families of adult sufferers of AN who developed a chronicity of the ED. The current research suggests the need for guidelines for families specifically targeted towards adult men's care and treatment of AN. Recommendations should take into consideration the strategies which have helped the men in the past to begin developing guidelines aimed at alleviating families' difficulties in addressing their loved ones' ED.

Bulik et al. (2012; Kirby et al., 2015) developed Uniting Couples in the treatment of Anorexia Nervosa (UCAN), a model for adults with AN who are in committed relationships. As shown in the present study and highlighted in previous literature, romantic and family relationships impact greatly on the sufferers' experience of AN. Moreover, although not explored in this study, Bulik and colleagues (2012) contended that, whilst understanding the seriousness and risks of AN, partners may feel helpless and "muted" (p.25). Therefore, development of couple therapy designed around male sufferers' experiences, needs and difficulties, and inclusion of their partners, is pressing. This should include psychoeducational components, as past studies explain that partners appear to be uninformed (Schmit & Bell, 2017) around the illness. It is felt that this kind of intervention would help both sufferers, their partners and their relationship.

In the wake of the current financial climate which is inflicting cuts on the NHS it seems important to work towards more sustainable interventions, such as using group work as

mentioned and in working towards prevention. Räisänen and Hunt (2014) showed that professionals, family members and others around ED male sufferers at times failed to respond to difficulties. This was validated by the current study where some of the men reported that their families may have shied away from their sons' problems. Perhaps these behaviours were informed by feeling helpless and not knowing how to manage an ED, but also perhaps because parents failed to link AN with being male. It is imperative that men's EDs do not go unnoticed. Numerous studies have shown that delaying care for EDs impacts on MoC, and on the increasing duration and laboriousness of recovery (Carter et al., 2012). CP practice could be improved through encouraging psychoeducational groups for teachers and lecturers to raise awareness of EDs across a variety of educational contexts. Identifying early signals of AN (such as isolation and changing exercise and food patterns) and carrying out preventive work such as addressing MH and vulnerability for males, might engender a sense of safety for boys to come forward and ask for help. It is anticipated that these types of campaigns could help parents, carers and partners in supporting their loved ones. It is also suggested to teach boys and girls in schools about MH difficulties to dispel myths that EDs are only for girls. These actions might help to deconstruct the social definitions of hegemonic masculinity which this study and previous literature have shown to be widely acknowledged and prevalent.

The researcher recommends that the NHS continues building working partnerships with organisations like BEAT and MGEDT to develop campaigns to raise awareness and promote knowledge around AN in men. These campaigns could be directed towards sufferers, those at risk of developing EDs and the wider society. Events such as talks and informative evenings could take place within education settings, GP practices, local libraries and public offices. Use of social media platforms such as Twitter, Instagram, and Facebook could directly disseminate knowledge and effectively reach a younger audience. This might also indirectly facilitate networking between former and current sufferers, families and carers through the creation of virtual communities. These campaigns could be promoted on radio and television programmes, and via social media platforms which are increasingly used by ED sufferers and the wider population (Moorhead et al., 2013). It seems important to involve former sufferers in these campaigns, enabling them to tell their stories and draw on their experiences. This may allow these men to feel fulfilled by their contribution to helping other males struggling with AN. Moreover, those still suffering with AN will gain a sense of commonality, and shared experience, which seems to be missing in many of the participants' experiences. Sense of shared experience was identified as helpful for participants' MoC and in the journey through recovery. As Dayal, Weaver, and Domene (2016) proposed, encouraging a sense of safety and belonging, and redefining ideals, may



help in fostering resilience and overcoming shame. It is thought that increasing MH awareness will help lift prejudices around ED difficulties and may encourage people to come forward to seek support rather than isolate.

Society at large is considered one of the institutions responsible for perpetuating shame in men with EDs (Courtenay, 2000). However, men's own beliefs, attitudes and behaviours may play a role in maintaining these gender constructs, due to seeking isolation rather than help (Courtenay, 2000). Using group psychoeducation and peer support within EDs services can help families assist their loved ones and diminish feelings of blame and guilt, and can help families in assisting the men. Involving families and partners in treatment and psychoeducational groups already takes place across some services (Hibbs, Rhind, Leppanen, & Treasure, 2015), but groups specifically created for families of male sufferers are needed. Treasure et al. (2008) argued that conceptualising AN within a medical framework can perhaps support families and partners in better understanding EDs. Taking this approach may help families and sufferers to appreciate each other's needs and enhance their communication. Increasing knowledge of MH and AN for parents may also help demystify AN and the ways that men may experience it. Psychoeducational group settings might also help in dispelling stereotypes around men and their vulnerability to EDs. Challenging these prejudices can help in lifting the stigma which the men are burdened by, and can help in tempering possible perceived shame. This seems particularly relevant for men with EDs and their partners who, as seen from the interviews and previous research (Bulik et al., 2012), may still be subject to feelings of embarrassment, blame and emotional avoidance.

It is critical to note that similar emotional experiences around AN can potentially lead men to react in contrasting ways. For example, William's response to feeling shame differed to Matt and Liam's where shame appeared to be conducive to maintaining AN. This suggests the importance of valuing individual perceptions of emotions and thoughts, and the relevance that these personal understandings may have in therapeutic settings. In the context of challenging emotions such as shame and loneliness, collaboratively using socratic questioning based on curiosity and openness may help CPs and clients to examine the advantages and disadvantages of difficult feelings. Moreover, socratic questioning may help clients challenge distorted thinking and work towards cognitive restructuring. These interventions are widely used in treatment of EDs including AN (Guarda & Attia, 2018) and this study suggests its continued use.

### *5.6.3. Connecting*

In the current research, perceived incongruence between AN, the participants' identity and their value systems, seemed to trigger motivation and suggested an imminent change. As proposed by Mulkerrin et al. (2016), incongruence between the individual and AN's values can create significant openings to act therapeutically, facilitating MoC and recovery. The findings of this study complement Harris's (2006) overview on Acceptance Commitment Therapy (ACT) as he proposed that behaving in ways counter to one's internal value system can cause distress. The researcher advises ACT for men to address experiential avoidance, poor experiential awareness and lack of motivation which characterised many of the participants' experiences.

For a number of the men, offering their experience to allow other sufferers to connect with their experiences was a key reason to participate in the study. This study highlighted that during their journey with AN, men may have difficulty coming forward to seek help, thus contributing to the under-acknowledgement of their experiences of this ED. The lack of sense of connection and commonality with other men, has been voiced throughout interviews. It is anticipated that the implementation of group therapy for males only within NHS inpatient and outpatient services, can help dispel stigma around the AN diagnosis for sufferers. Support groups for male ED sufferers exist, however they are generally organised by charities (MGEDT, 2017). Moreover, through connecting to others' vulnerabilities, men may be more likely to be open and disclose their own stories. The provision of these groups would increase ED awareness within health services, therefore increasing the chance of GPs, families and professional systems around sufferers recognising men's EDs, and the likelihood of referrals for support. Greater awareness would start to challenge the stereotype of EDs being female-only illnesses, allowing men to feel more confident in seeking help when they feel vulnerable. Where possible the researcher recommends group settings as they provide an opportunity for men to share experiences with other men. In addition, group settings effectively respond to the need for developing sustainable interventions in the context of the financial restraints that the public health sector is currently confronted with.

### *Theory and practice links*

It seems relevant for CPs to help clients to establish a sense of identity and a sense of self separate from AN. Williams, King and Fox (2016) contended that this means creating a new identity and rebuilding a self "somewhat dissociated from" (p. 222) the person they had been, allowing for reinvention. Gergen (2011) affirmed there can be multiple senses of self which depend on our social context.

The men's urge to share their personal journeys in the interviews, threw light on the relevance of NT (White, 2011) for men with AN, not only for themselves but in supporting others. As mentioned in the Discussion (section 5.3.2.), visions of past, present, and future selves seemed to allow the men to work with their perceived vulnerabilities, serving as motivation for change. Moreover, they used their honesty and openness to reach out to other sufferers, diffusing a sense of shared experience. This process of connecting to one's own sense of self and experience, and revealing it to others, emerged as crucial in their life journeys. The men were 'writing' their own stories and wanted to help other sufferers rewrite theirs. The men created alternative stories, away from their journey with AN, by using social media platforms, writing blogs or articles, giving public speeches, and through participating in the current study. Whilst pursuing their preferred means, they connected with their own feelings and experiences; and self-disclosed safely and significantly. Botha (2012) argued that "dominant societal forces, attitudes, and discourses" (p.150) usually feature in traditional therapeutic settings and approaches. According to the researcher through NT, individuals may have the opportunity to regain their power and reconstruct their sense of identity, by taking "control, responsibility and accountability" of their subjective reality (p.150). NT does not rely on a professional's diagnosis of a client's problem. It is based on "accepting the nature of any problem from the client's narrative, that is personified by the client in the context of his story line" (Botha, 2012, p.162). This form of therapy allows individuals to feel empowered, working collaboratively with their therapist and recognising the possible origins and elements of their difficulties. This therapeutic approach seems to be pertinent to the participants' urge to 'come clean', as it possesses "deconstructive abilities" (Botha, 2012, p.162) necessary to let go of dominant discourses on masculinity and AN. Moreover, NT seems to lend itself to construct subjectivities based on individuals' unique personal "beliefs, values, hopes" (Botha, 2012, p.162).

Engaging in the relational approach of NT requires profound respect between therapist and client and is not directly oriented towards growth and change (White, 2007). However, at the same time as externalising problems (in this case, AN) from clients' sense of self, it is important not to foster a dualistic conceptualisation of the self into 'real self' versus 'anorexic self'. Vitousek (2005) invited readers to ponder over the importance of integrating the 'negative experiences' of AN into narratives of sufferers. If we fail to address the egosyntonic qualities of each individual's experience of AN, this may distance the clinician from the client (Conti et al., 2016). Moreover, acknowledging ambivalence and incongruence between MoC and taking action is deemed essential (Conti et al., 2016).

## 5.7. Avenues for Future Research

This IPA research set out to give voice to the men's individual understandings of their experience of MoC in their AN journey. This is a qualitative study with eight men, therefore the researcher acknowledges the cohort's possible non-representativeness of the entire AN male population. Nevertheless, the participants' contributions suggest the transferability of their understandings in considering future research avenues.

### *Ff and perfectionism*

Ff emerged as a key theme for all the interviewees. It was interesting to observe the way Ff affected the men at a variety of stages during their journey with AN, and the relationship between Ff and MoC. Although found frequently in people who experience MH issues such as anxiety, Ff seems underexplored in EDs and particularly in AN. Conroy and colleagues' (2007) study focused on the connection between Ff and perfectionism, defining Ff as an underlying force of perfectionism. This seemed to reflect the current study's participants' narratives as they linked their Ff with perfectionism. Peterssen, Johnsson and Perselus's (2017) acknowledged the significance of investigating "personal" definitions and manifestations of perfectionism as they showed that psychometric tools may not capture the meaning that this holds for individuals, nor its expression. With this in mind, it seems vital to conduct qualitative research exploring Ff in men in relation to their MoC whilst experiencing AN. It might be interesting to use discourse analysis to explore people's cognitions through their verbal expression. This method can help researchers' and clinicians' understanding of men's processes of making sense of and of 'constructing' and maintaining their beliefs around Ff. The researcher hopes that this will help improve professionals' understanding of men's experiences, to support them along their recovery path. Moreover, given the thought-provoking link between behavioural, physical and cognitive diagnostic criteria of AN and perfectionism, and the relationship between Ff and perfectionism, further exploration seems relevant to potentially uncovering a new area within AN research. This area of research may illuminate Ff's role in MoC, and in achieving full recovery.

### *The role of families and partners*

The relevance of the men's relationship with their partners and parents appeared central. The men described the importance of their loved ones' presence, understanding and patience. Motivation emerged not only in the men but also in the men's perceptions of their parents' or partners' support and presence. There seems to be a lack of enquiries regarding

parents' and partners' perception of their own involvement with male sufferers in their journey with AN, and more specifically the perceived impact of this on men's MoC.

More research aimed at exploring romantic relationships, where the sufferer is male, is needed. As observed, for the participants, partners played a central role in their MoC and wider experience of AN. Research has been conducted with partners of women who had an experience of AN (Schmit & Bell, 2017). Understanding the partners' experiences, hopes and needs is important as their role in the men's lives seems to be significant and hence clinical services should support them. The EDs team at the Maudsley Hospital in London (Treasure et al., 2016) has developed a model offering support to families and partners to help them care for their loved ones with EDs, however a more stringent focus on men might uncover key aspects. To gauge the underlying dynamics of relationships with male sufferers it would be fascinating to conduct a qualitative study interviewing the couple together and separately. Future research could also include focus groups with partners only and sufferers only to increase understanding of the complex behaviours and motivation which may be elicited through the group dynamic (Morgan, 1997).

Whilst discussing their romantic relationships, some of the participants admitted eating more and being more concerned around the quality of their food when with their partners. Given the influence that partners had on the men, it could be beneficial to conduct a study on partners of men with AN and their relationships with food. Therapeutic interventions regarding food in the couple relationship, may be devised from a future exploration.

Interestingly, none of the men in the study spoke about the relationships between their parents. A study exploring the relationship between parents who have a son suffering with AN is needed. This exploration could shed light on important dynamics impacting on communication amongst family members, their well-being and the maintenance of AN.

Most of the past AN studies focused on the impact of families on women's, or adolescents', recovery. The current study confirms that MoC is a crucial element in recovery and that parents can be pivotal in sufferers' experiences regardless of age. It seems that little research has explored the impact of parents on sufferers' MoC, particularly young and adult men. Zaitsoff and Taylor (2009) demonstrated that adaptive parent-daughter relationships contribute to an increase in MoC. The current research found that conflictual relationships with fathers' impact on MoC in different ways. Given the significance of both parents' involvement on the men's drive to change, it may be useful to carry out phenomenological research exploring the qualities of young and adult men's relationships with each of their

parents. Using genograms in therapeutic work is advisable to improve CPs understanding of interactions between family members in the context of EDs (Leonidas & Santos, 2015). Genograms are used in therapy for EDs in women (Leonidas & Santos, 2015) and could be equally valuable in conducting research and therapy with men and their family members. Genograms may help researchers and practitioners in tracking relationship patterns, generational relationships with food and emotions, and eliciting further curiosity around difficult dynamics in families. Improving an understanding of the dynamics which may ensue from these bonds may inform systemic practice interventions aimed at devising ways of supporting both parents and sufferers and perhaps other family members.

### *Gender and sexuality*

Moulding (2015) conducted a study with women on gendered intersubjectivities of recovery from an ED. Her account highlighted the way changes in perspective on gendered social dimensions, supported participants with new ways of experiencing their sense of “belonging, recognition, self-acceptance and agency” (p.70). To further elucidate men’s sense-making of their journeys with AN, research might benefit from further analysing men’s narratives of recovery, particularly focusing on the way that gender and gender norms inform men’s accounts of gendered social dimensions. It seems relevant to continue exploring these experiences for men, in particular the way the egosyntonicity of AN changed for them during the course of their journeys with this illness, in relation to their understanding of gender.

More research needs to focus on sufferers’ experiences across the whole spectrum of genders and sexualities. This is critical in raising awareness and challenging biased beliefs around the incidence of EDs. Furthermore, to increase the validity of future enquiries, the researcher suggests that these types of studies would allow participants to express their gender and sexuality, as past enquiries can be critiqued for providing limited options regarding how to identify oneself (Feldman & Meyer, 2007).

The current study showed how, although the onset of AN may indeed occur during the males’ teenage years, it is often carried into their adult lives. It could be beneficial to focus on adult and older adult men’s experiences of AN, as most of the research on males’ experiences and understanding of AN at present seems to have been directed towards adolescents (Darcy, 2011; Darcy et al., 2012). Researchers may want to conduct future studies focusing on cohorts which contain specific age ranges for onset and duration of the illness, granting increased homogeneity of the samples, therefore improving research quality.

Quantitative research with men who experienced AN would be important to increase awareness of EDs in men and to expand the range of the experiences which they have endured to inform clinical practice. Purposive sampling and homogeneity may fail to offer representativeness of an entire population, it would therefore be important to carry out a similar study using quantitative methods.

## **5.8. Concluding Comments**

This study sought to explore men's experience of MoC in relation to their journey with AN using the IPA approach. Eight men who had an experience of AN participated in the research which involved semi-structured interviews. These interviews were subsequently transcribed and analysed using the IPA method.

This is one of very few qualitative enquiries focusing on men's experiences of AN (Darcy et al., 2012; Geugen et al., 2012). To my knowledge, it is the first to explore MoC in relation to AN in men. Furthermore, MoC has rarely been considered in depth as generally it is addressed in quantitative research. Therefore, the idiographic qualities which emerged from this research and its findings have significant, exciting implications for CP and the individual treatment of each case of AN. Besides the findings, limitations and critical reflections presented, clinical implications for CPs and avenues for research have been proposed to encourage further exploration of the phenomenon.

Conducting this research has been an arduous learning journey. Whilst aiming to stay true to the participants' narratives and their idiographic value, the researcher attempted to find emerging patterns representing the cohort. The master themes 'sense of control', 'me and the world', and 'connecting' offer descriptive accounts of the men's experiences of their journeys with their AN.

Some of the men's experiences appear to validate previous findings, however their narratives have uncovered novel ideas. The findings have shown that, for most of the participants, MoC seems 'governed' by their sense of control which manifested in different ways across participants. This research invites professionals to rethink the way the concepts of MoC and sense of agency are applied during the course of AN for men. At the onset of AN, their drive was directed towards engaging in *harmful* or detrimental behaviours towards their health, whereas at a later stage in their experience the men were moved towards favourable behaviours of self-preservation and care, hence challenging the egosyntonicity of

AN. Therefore, the researcher finds that the way men's MoC impacts personal agency in AN may shift existing thinking in relation to its chronological position and function for male sufferers.

The systems around the men emerged as crucial in their journey with AN, having a meaningful impact on their MoC. Their experiences were characterised by struggles to communicate, feel understood and feel accepted by the world, whilst experiencing their AN. Nevertheless, a need to connect to others, and share their experiences, pervaded their existence during, and after, their journey with recovery. This need to connect seemed to be interlinked with their MoC. In some instances, when the men managed to relate to others' vulnerabilities, this enabled them to connect to their own, and this process acted as a catalyst for change.

It could be argued that some of the men's experiences which emerged from the interviews have been or could be experienced in comparable ways by women. This could therefore lend support to previous literature stating that men and women have similar journeys with AN (Hay et al., 2005; Striegel et al., 2012). However, these participants' experiences seemed to be permeated by 'additional' layers of complexity due to the interconnection of their AN with masculinity.

Despite its intricacies and idiosyncrasies, MoC also showed common features for these men who each had a unique experience of AN. The views of the men encourage reflections on the role of CPs in supporting them and the systems around them. The 'added' complexities experienced by male sufferers ought to drive researchers, families, and clinicians alike to finding ways to better assist this population. It is suggested that CPs explore new fields of research which may enable novel therapeutic interventions for AN to better meet the needs of certain marginalised populations.



## 6. References

- Abbate-Daga, G., Amianto, F., Delsedime, N., De Bacco C., & Fassino, S. (2013). Resistance to treatment and change in anorexia nervosa: a clinical overview. *BMC Psychiatry*, 13, 294-114.
- Abrams, D.B., Niaura, R., Brown, R.A. Emmons, K.M., Goldstein, M.G., & Monti, P.M. (2003). *The tobacco dependence treatment handbook*. New York: Guildford Press.
- Adams, C.E., & Leary, M.R. (2007). Promoting self-compassionate attitudes toward eating among restrictive and guilty eaters. *Journal of Social and Clinical Psychology*, 26(10), 1120-1144.
- Ali, K., Farrer, L., Fassnacht, D.B., Gulliver, A., Bauer, S., & Griffiths, K.M. (2017). Perceived barriers and facilitators towards help-seeking for eating disorders: a systematic review. *International Journal of Eating Disorders*, 50(1), 9-21.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental Disorders*. (4<sup>th</sup> ed. Text Revision). Washington, DC: APA.
- American Psychiatric Association (2013). *Diagnostic and statistical manual of mental Disorders*. (5<sup>th</sup> ed.). Washington, DC: APA.
- American Psychiatric Association. (2006) Practice guideline for the treatment of patients with eating disorders (3rd edition.) *American Journal of Psychiatry*, 163(suppl), 1–54.
- Anastasi, A. (1976). *Psychological testing*. (4<sup>th</sup> Ed.) NY: Prentice-Hall
- Andersen, A. (2013). Brief history of eating disorders in males. In Cohn, L. & Lemberg, R. (Eds.), *Findings on males with eating disorders* (pp.4-10). London: Routledge.
- Anderson, L.M., Reilly, E.E., Thomas, J.J., Eddy, K.T., Franko, D.L., Hormes, J.M., & Anderson, D.A. (2018). Associations of fear, disgust, and eating pathology in undergraduate men and women. *Appetite*. doi: 10.1016/j.appet.2018.02.017
- Arcelus, J., Mitchell, A.J., Wales, J., & Nielsen S. (2011). Mortality rates in patients with

- anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7), 624-731.
- Arcelus, J., Haslam, M., Farrow, C., & Meyer, C. (2013). The role of interpersonal functioning in the maintenance of eating psychopathology: A systematic review and testable model. *Clinical Psychology Review*, 33(1), 156-167.
- Arcelus, J., Yates, A., & Whiteley, R. (2012). Romantic relationships, clinical and sub-clinical eating disorders: A review of the literature. *Sexual and Relationship Therapy*, 27, 147–161.
- Aspen, V., Darcy, A.M., & Lock, J. (2014 September 14). Patient resistance in eating disorders. *Psychiatric Times*. Retrieved from: <http://www.psychiatrictimes.com/eating-disorders/patient-resistance-eating-disorders>.
- Bardone-Cone, A.M., Sturm, K., Lawson, M.A., Robinson, D.P., & Smith, R. (2010). Perfectionism across stages of recovery from eating disorders. *International Journal of eating Disorders*, 43, 139-149.
- Barker, C., & Pistrang, N. Elliot, R. (2002). *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners*. Chichester: Wiley.
- BEAT. (2018). [online] Retrieved from: <https://www.beateatingdisorders.org.uk/media-centre/eating-disorder-statistics> [Accessed on 30 January 2018].
- Becker, A.E., Thomas, J.J., & Pike, K.M. (2009). Should non-fat-phobic anorexia nervosa be included in DSM-V? *International Journal of Eating Disorder*, 42(7), 620-35.
- Behnke, E. (2011). Edmund Husserl: Phenomenology of Embodiment. In J. Fieser & B. Dowden (eds.), *Internet Encyclopaedia of Philosophy*. Retrieved from: <http://www.iep.utm.edu/husspemb/>.
- Birgegard, A., Gross, G., de Man Lapidoth, J., & Norring, C. (2013). DSM 5: problems and suggestions, *Journal of Eating Disorders*, 1:8.
- Blaikie, N. (2000). *Designing Social Research*. Cambridge: Polity.

- Bodell, L.P., & Keel, P.K. (2010). Current treatment for anorexia nervosa: efficacy, safety, and adherence. *Psychological Research Behaviour Management*, 3, 91-108.
- Bora, E., & Köse, S. (2016). Meta-analysis of theory of mind in anorexia nervosa and bulimia nervosa: A specific impairment of cognitive perspective taking in anorexia nervosa?. *International Journal of Eating Disorders*, 49(8), 739-740.
- Botha, D. (2012). *No Labels – Men in Relationship with Anorexia*. South Africa: Moonshine Media.
- Braun, V., & Clarke, V. (2013). *Successful Qualitative Research*. London: Sage.
- British Psychological Society Generic Professional Practice Guidelines (2008). [online] Retrieved from: [bps.org.uk/sites/default/files/documents/generic\\_professional\\_practice\\_guidelines.pdf](https://www.bps.org.uk/sites/default/files/documents/generic_professional_practice_guidelines.pdf) [Accessed on 1 June 2018]
- British Psychological Society Division of Counselling Psychology Professional Practice Guidelines (2005). [online] Retrieved from: [bps.org.uk/sites/default/files/documents/professional\\_practice\\_guidelines\\_division\\_of\\_counselling\\_psychology.pdf](https://www.bps.org.uk/sites/default/files/documents/professional_practice_guidelines_division_of_counselling_psychology.pdf) [Accessed on 28 April 2018]
- British Psychological Society (2014). [online] Retrieved from: [https://www1.bps.org.uk/system/files/Public%20files/inf180\\_web.pdf](https://www1.bps.org.uk/system/files/Public%20files/inf180_web.pdf) [Accessed on 30 December 2017].
- British Psychological Society Code of Ethics and Conduct (2018). [online] Retrieved from: <https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%282018%29.pdf> [Accessed on 28 April 2018].
- Brown, A., Mountford, V.A., & Waller, G. (2013). Is the therapeutic alliance overvalued in the treatment of eating disorders?. *International Journal of Eating Disorders*, 46, 779-782.
- Bruch, H. (1962). Perceptual and conceptual disturbances in anorexia nervosa. *Psychosomatic medicine*, 24(2), 187-194.

- Bruch, H. (1978). *The Golden Cage: The Enigma of Anorexia Nervosa*. Cambridge, MA: Harvard University Press.
- Bulik, C. M., Baucom, D. H., & Kirby, J. S. (2012). Treating Anorexia Nervosa in the Couple Context. *Journal of Cognitive Psychotherapy*, 26(1), 19–33.
- Bunnell, D. (2010). Men with eating disorders. The art and science of treatment engagement. In M. Maine, B. McGilley, & D. Bunnell (Eds.) *Treatment of Eating Disorders: Bridging the Research Practice Gap* (pp. 301-316). New York: Elsevier.
- Burgess, R.G. (1984). *In the Field: An Introduction to Field Research*, London: Allen and Unwin.
- Butler, J. (1988). Performative acts and gender constitution: as essay in phenomenology and feminist theory. *Theatre Journal*, 40(4), 519-531.
- Button, E., Aldridge, S., & Palmer, R. (2008). Males assessed by a specialized adult eating disorders service: patterns over time and comparisons with females. *International Journal Eating Disorders*, 41, 758–61.
- Calado, M., Lameiras, M., Calado, M., Sepulveda, A., Lameiras, M., Rodríguez, Y., Carrera, M. (2010). The mass media exposure and disordered eating behaviors in Spanish secondary students. *European Eating Disorders Review*, 18(5), 417-427.
- Carlat, D.J., Camargo, C.A., & Herzog, D.B. (1997). Eating disorders in males: A report on 135 patients. *American Journal of Psychiatry*, 154, 1127-1132.
- Carter, J.C., & Kelly, A.C. (2015). Autonomous and controlled motivation for eating disorders treatment: Baseline predictors and relationship to treatment outcome. *British Journal of Clinical Psychology*, 54(1), 76-90.
- Carter, O., Byrne, S., Allen, K., & Fursland, A. (2014). Readiness and motivation to change in the treatment of adults with anorexia nervosa: a case series *Journal of Eating Disorders*, 2(Suppl1), O8. <http://doi.org/10.1186/2050-2974-2-S1-O8>

- Carter, O., Pannekoek, L., Fursland, A., Allen, K.L., Lampard, A.M., & Byrne, S.M. (2012). Increased wait-list time predicts dropout from outpatient enhanced cognitive behaviour therapy (CBT-E) for eating disorders. *Behavior Research and Therapy*, 50(7-8), 487–92.
- Casasnovas, C., Fernández-Aranda, F., Granero, R., Krug, I., Jiménez-Murcia, S., Bulik, C.M., & Vallejo-Ruiloba, J. (2007). Motivation to change in eating disorders: clinical and therapeutic implications. *European Eating Disorders Review*, 15(6), 449-456.
- Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1999. (Treatment Improvement Protocol (TIP) Series, No. 35.) Chapter 1 Conceptualizing Motivation And Change. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK64972/>.
- Chapman, E., & Smith, J.A. (2002). Interpretative phenomenological analysis and the new genetics. *Journal of Health Psychology*, 7(2), 125-130.
- Charmaz, K. (1995). Identity dilemmas of chronically ill men. In D., Sabo, & D.F. Gordon (Eds.), *Men's Health and Illness: Gender, Power and the Body* (pp. 266-291). Thousand Oaks, CA: Sage Publications.
- Chesny, E., Goodwin G.M., & Fazel S. (2014). Risks of all-cause and suicide mortality in mental disorders: a meta-review. *World Psychiatry*, 13(2), 153-160.
- Chung, R. J., & Bravender, T. (2011). Disordered eating in boys: Beyond the DSM-IV. *Contemporary Pediatrics*, 28(12), 26-34.
- Clausen, L., Lubeck, M., & Jones, A. (2013). Motivation to change in the eating disorders: a systematic review. *International Journal of Eating Disorders*, 46, 755-763.
- Cockell, S. J., Hewitt, P. L., Seal, B., Sherry, S., Goldner, E. M., Flett, G. L., & Remick, R. A. (2002). Trait and self-presentational dimensions of perfectionism among women with AN. *Cognitive Therapy And Research*, 26(6), 745-758.
- Cohn, L., & Lemberg, R. (2013). *Current Findings on Males and Eating Disorders*. London: Routledge.

- Comtois, K.A., Elwood, L., Holdcraft, L.C., Simpson, T.L., & Smith, W.R. (2007). Effectiveness of dialectical behaviour therapy in a community mental health center. *Cognitive and Behavioural Practice*, 14, 406-414.
- Connell, R.W., & Messerschmidt, J.W. (2005). Hegemonic masculinity – rethinking the concept. *Gender & Society*, 19(6), 829-859.
- Conroy, D.E., Kaye, M.P., & Fifer, A.M. (2007). Cognitive links between fear of failure and perfectionism. *Journal of rational-emotive & cognitive-behavior therapy*, 25(4), 237-253.
- Conti, J., Rhodes, P., & Adams, H. (2016). Listening in the dark: Why we need stories of people living with severe and enduring anorexia nervosa. *Journal of Eating Disorders*, 4(1). doi:10.1186/s40337-016-0117-z
- Cooley, C.H. (1902). *Human Nature and the Social Order*. New York: Scribner's.
- Copperman, J. (2000). *Eating Disorders in the United Kingdom: Review of the Provision Of Health Services for Men with Eating Disorders*: Norwich: Eating Disorders Association.
- Costa, S., Hausenblas, H.A., Oliva, P., Cuzzocrea, F., & Larcán, R. (2016). Maladaptive perfectionism as mediator among psychological control, eating disorders, and exercise dependence symptoms in habitual exerciser. *Journal of Behavioral Addictions*, 5(1), 77-89.
- Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science and Medicine*, 50(10), 1385-1401.
- Courty, A., Godart, N., Lalanne, C., & Berthoz, S. (2014). Alexithymia, a compounding factor for eating and social avoidance symptoms in anorexia nervosa. *Comprehensive Psychiatry*, 56, 217-228.
- Crisp, A.H., Gelder, M.G., Rix, S., Meltzer, H.I., & Rowlands, O.J. (2000). Stigmatisation of people with mental illnesses. *The British Journal of Psychiatry*, 177(1), 4-7.

- Crocker, J., & Knight, K.M. (2005). Contingencies of self-worth. *Current Directions in Psychological Sciences*, 14(4), 200-204.
- Crowell, S.E., Beuchaine, T.P., & Linehan, M.M. (2009). A biosocial developmental model of borderline personality: elaborating and extending Linehan's theory. *Psychological Bulletin*, 135(3), 495-510.
- Cuban, B. (2013). *Shattered Image: My Triumph Over Body Dysmorphic Disorder: My Triumph Over Body Dysmorphic Disorder*. Pasadena, CA: Net Minds Corporation.
- Currin L., Waller G., Treasure J., Nodder J., Stone C., Yeomans M., Schmidt U. (2007). The use of guidelines for dissemination of 'best practice' in primary care of patients with eating disorders. *International Journal of Eating Disorders*, 40(5), 476–479.
- Dally, P. (1977). Anorexia nervosa: Do we need a scapegoat? *Proceedings of the Royal Society of Medicine*, 70, 470-474.
- Danielsen, Y.S., Årdal Rekkedal, G., Frostad, S., & Kessler, U. (2016). Effectiveness of enhanced cognitive behavioural therapy (CBT-E) in the treatment of anorexia nervosa: a prospective multidisciplinary study. *BMC Psychiatry*, 16, 342. doi: <https://bmcpsy psychiatry.biomedcentral.com/articles/10.1186/s12888-016-1056-6>
- Darcy, A. (2011). Eating Disorders in Adolescent Males: An Critical Examination of Five Common Assumptions. *Adolescent Psychiatry*, 1(4), 307-312.
- Darcy, A.M., Doyle, A.C., Lock, J., Peebles, R., Doyle, P., & Le Grange, D. (2012). The eating disorder examination in adolescent males with anorexia nervosa: How does it compare to adolescent females?. *International Journal of Eating Disorders*, 45, 110-114.
- Dare, C., & Eisler, I. (1997). Family therapy for anorexia nervosa. In D.M. Garner & P.E. Garfinkel (Eds). *Handbook of Treatment for Eating Disorders* (pp. 307-324). New York: The Guilford Press.
- Dare, C., Le Grange, D., Eisler, I., & Rutherford, J. (1994). Redefining the psychosomatic family: The pre-treatment family process in 26 eating disorder families. *International*

*Journal of Eating Disorders*, 16, 211–226.

Dawson, L., Rhodes, P., & Touyz, S. (2014). "Doing the Impossible" The Process of Recovery From Chronic Anorexia Nervosa. *Qualitative health research*, 24(4), 494-505.

Dayal, H., Weaver, K., & Domene, J.F. (2015). From shame to shame resilience: narratives of counselor trainees with eating issues. *Qualitative Health Research*, 25(2), 153-67.

de Visser, R.O. & McDonnell, E.J. (2012). "That's OK. He's a guy: a mixed-methods study of gender double-standards for alcohol use. *Psychology & Health*, 27(5), 618-639.

Deci, E.L., & Ryan, R.M. (1985). *Intrinsic motivation and Self Determination in Human Behavior*. New York: Plenum Press.

Deci, E.L., & Ryan, R.M. (2000). The "what" and "why" of goal pursuits.: Human needs and the self-determination of behavior. *Psychological Inquiries*, 11, 207-219.

Deckers, L. (2013). *Motivation: biological, psychological, and environmental*. New York: Routledge.

Diekmann, A.B., & Eagly, A.H. (2008). Of men, women, and motivation: A role congruity account. In Shah, J.H., & Gardner, W.L. (Eds.), *Handbook of Motivation Science* (pp. 434-447). New York: Guilford.

Dimitropoulos, G., & Klopfer, K. (2009). Caring for a sibling with anorexia nervosa. A qualitative study. *European Eating Disorders Review*, 17, 350–365.

Douglas, B., Woolfe, R., Strawbridge, S., Kasket, E., & Galbraith, V. (2016). *The Handbook of Counselling Psychology* (Fourth ed.) London: Sage.

Dovydaityene, M., & Maslauskienė, I. (2013). Illness perception and motivation to recover in eating disorders. *Procedia - Social and Behavioral Sciences*, 84, 1217-1220.

Dray, J., & Wade, T.D. (2012). Is the transtheoretical model and motivational interviewing approach applicable to the treatment of eating disorders? A review. *Clinical Psychology Review*, 32(6), 558-565.



- Drummond, M.J. (2002). Men, body image, and eating disorders. *International Journal of Men's Health*, 1, 89.
- Drummond, J. (2007). Phenomenology: Neither auto- nor hetero- be. *Phenomenology and the Cognitive Sciences*, 6, 57-74.
- Duncan, T.K., Sebar, B., & Lee, J. (2015). Reclamation of power and self: a meta-synthesis exploring the process of recovery from anorexia nervosa. *Theory, Research, and Practice*, 3(2), 177-190.
- Eatough, V., & Smith, J.A. (2008). "Interpretative phenomenological analysis" in C. Willig & W. Stainton Rogers, (eds.), *Handbook of Qualitative Psychology*, pp.179-194, London: Sage.
- Eddy, K.T., Keel, P.K. Dorer, D.J., Delinsky, S.S., Franko, D.L., & Herzog, D.B. (2002). Longitudinal comparison of anorexia nervosa subtypes. *International Journal of Eating Disorders*, 31(2), 191-200.
- Engman-Bredvik, S., Carballeira Suarez, N., Levi, R., & Nilsson, N. (2015). Multi-family therapy in anorexia nervosa - A qualitative study of parental experiences. *Eating Disorders*, 24(2), 186-197.
- Eli, K. (2014). Between difference and belonging: Configuring self and others in inpatient treatment for eating disorders. *PLoS One*, 9(9), e105452.
- Elison, J., & Partridge, J.A. (2009). Relationships between shame-coping, fear of failure, and perfectionism in college athletes. *Journal of Sport Behavior*, 35(1), 19-39.
- Elliott, R. & Timulak, L. (2005). Descriptive and interpretive approaches to qualitative research. In J. Miles & P. Gilbert (eds.), *A Handbook of Research Methods in Clinical and Health Psychology* (pp. 147-159). Oxford, UK: Oxford University Press.
- Ellis, L. A., Collin, P., Hurley, P. J., Davenport, T. A., Burns, J. M., & Hickie, I. B. (2013). Young men's attitudes and behaviour in relation to mental health and technology: implications for the development of online mental health services. *BMC psychiatry*, 13(1), 119.

- Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity? *Social Science & Medicine*, 62(9), 2246-2257.
- Espel, H. M., Goldstein, S. P., Manasse, S. M., & Juarascio, A. S. (2016). Experiential acceptance, motivation for recovery, and treatment outcome in eating disorders. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity*, 21(2), 205-210.
- Fade, S. (2004). Using interpretative phenomenological analysis for public health nutrition and dietetic research: a practical guide. *Proceedings of the Nutrition Society*, 63, 647-653.
- Fairburn, C.G. (2005). Evidence-based treatment of anorexia nervosa. *International Journal of Eating Disorders*, 37, S26-S30.
- Fairburn, C.G., Cooper, Z., Doll, H.A., & Welch, S.L. (1999). Risk factors for anorexia nervosa: three integrated case-control comparisons.. *Archives of General Psychiatry*, 56(5), 468-76.
- Fassino, S., Pierò, A., Tomba, E., & Abbate-Daga, G. (2009). Factors associated with dropout from treatment for eating disorders: a comprehensive literature review. *BMC Psychiatry*, 9(67) <https://doi.org/10.1186/1471-244X-9-67>.
- Feldman, M.B., & Meyer, I.H. (2007). Eating disorders in diverse lesbian, gay, and bisexual populations. *International Journal of Eating Disorders*, 40(3), 218-226.
- Fichter, M.M., & Daser, C. (1987). Symptomatology, psychosexual development and gender identity in 42 anorexic males. *Psychological Medicine*, 17(2), 409-418.
- Finlay, L. (2002). Outing the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12, 531-545.
- Finlay, L. (2003) Through the looking glass: inter-subjectivity and hermeneutic reflection, In L. Finlay & B. Gough (Eds.) *Reflexivity: a practical guide for researchers in health and social science*. Oxford: Blackwell Publishing.

- Finlay, L. (2008). A dance between the reduction and reflexivity: Explicating the "phenomenological psychological attitude". *Journal of Phenomenological Psychology*, 39(1), 1-32.
- Finlay, L., & Steward, B. (2006) Disseminating the research: towards making knowledge, in L. Finlay & C. Ballinger (Eds.) *Qualitative Research for Health Professionals: Challenging Choices*. Chichester: John Wiley Publishers.
- Fischer, M.S., Baucom, D.H., Kirby, J.S., & Bulik, C.M. (2015). Partner distress in the context of adult anorexia nervosa: The role of patients' perceived negative consequences of AN and partner behaviors. *International Journal of Eating Disorders*, 48(1), 67-71.
- Fogarty, S. & Ramjan, L.M. (2016). Factors impacting treatment and recovery in anorexia nervosa: qualitative findings from an online questionnaire. *Journal of Eating Disorders*, 4, 18 <http://doi.org/10.1186/s40337-016-0107-1>.
- 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., & Goss, K.P., (2012). *Eating and its disorders*. Chichester: Wiley and Sons.
- Frank, G. (1997). Is there life after categories? Reflexivity in qualitative research. *OTJR: Occupation, Participation and Health*, 17(2), 84-98.
- Foreich, F.V., Vartanian, L.R., Grisham, J.R., & Touyz, S.W. (2016). Dimensions of control and their relation to disordered eating behaviours and obsessive-compulsive symptoms. *Journal of Eating Disorders*, 4:14. <https://doi.org/10.1186/s40337-016-0104-4>
- Gale, C., Serpell, L., Holliday, J., Troop, N.A., & Treasure, J. (2006). The pros and cons of change in individuals with eating disorders: a broader perspective. *International Journal of Eating Disorders*, 39(5), 394-403.
- Garcia Jr., C., Seidinger, F.M., & Turato, E.R. (2013). What do we know about the father of

patients with anorexia nervosa or bulimia? *European Psychiatry*, 28,(1Suppl), 1.  
doi: [https://doi.org/10.1016/S0924-9338\(13\)76282-5](https://doi.org/10.1016/S0924-9338(13)76282-5)

- Geller, J., Brown, K.E., Srikameswaran, S., Piper, W., & Dunn, E.C. (2013). The psychometric properties of the Readiness and Motivation Questionnaire: a symptom-specific measure of readiness for change in the eating disorders. *Psychological Assessments*, 25(3) 659-668.
- Gergen, K. J. (2011). The self as social construction. *Psychological Studies*, 56(1), 108-116.
- Giorgi, A. (2002). The question of validity in qualitative research, *Journal of Phenomenological Psychology*, 33, 1-18.
- Giorgi, A., & Giorgi, B. (2008). Phenomenological psychology, in C. Willig & W. Stainton-Rogers (Eds). *The Sage Handbook of Qualitative Psychology*. London: Sage.
- Goldberg, H. (1976). *The hazards of being male: surviving the myth of masculine privilege*. Plainview, NY: Nash Publishing.
- Goss, K., & Gilbert, P. (2002). Eating disorders, shame and pride: A cognitive-behavioural Functional analysis. In P. Gilbert, & J. Miles (Eds.), *Body shame: Conceptualisation, research and treatment* (pp. 219–255). New York: Brunner-Routledge.
- Greenberg, S.T., & Schoens, E.G. (2008). Males and eating disorders: gender-based therapy for eating disorder recovery. *Professional Psychology: Research and Practice*, 39(4), 464-471.
- Greenberger, D., & Padesky, C (1995). *Mind over Mood: A cognitive Therapy Treatment Manual for Clients*. New York: Guilford Press.
- Gregertsen, E.C., Mandy, W., & Serpell, L. (2017). The egosyntonic nature of anorexia: An impediment to recovery in anorexia nervosa treatment. *Frontiers in Psychology*, 8.  
<https://dx.doi.org/10.3389%2Ffpsyg.2017.02273>.
- Griffiths, S., Mond, J.M., Murray, S.B., & Touyz, S. (2014). Young peoples' stigmatizing attitudes and beliefs about anorexia nervosa and muscle dysmorphia. *International Journal of Eating Disorders*, 47(2), 189-195.

- Griffiths, S., Murray, S.B., & Touyz, S. (2013). Disordered eating and the muscular ideal. *Journal of Eating Disorders*, 1, 15. <https://doi.org/10.1186/2050-2974-1-15>
- Grix, J. (2002). Introducing students to the generic terminology of social research. *Politics*, 22(3), 175-186.
- Guarda, A.S. (2008). Treatment of anorexia nervosa: insights and obstacles. *Physiology & Behavior*, 94, 113-120.
- Guarda, A. S., & Attia, E. (2018). Evidence-based practice and the residential treatment of eating disorders: Time to raise the bar. *Clinical Psychology: Science and Practice*, 25(1), e12232.
- Guegen, J., Godart, N., Chambry, J., Brun-Eberentz, A., Foulon, C., Divac, S.M., Guelfi, J.D., Rouillon, F., Falissard, B., Huas, C. (2012). Severe anorexia nervosa in men: comparison with severe AN in women and analysis of mortality. *International Journal of Eating Disorders*, 45, 537-545.
- Halmi, K.A, Agras, W.S., Crow, S., Mitchell, J., Wilson, G.T., Bryson S.W., Kraemer, H.C. (2005). Predictors of treatment acceptance and completion in anorexia nervosa: implications for future study designs. *Archives of General Psychiatry*, 62(7), 776–81.
- Harris, R. (2006). Embracing your demons: an overview of acceptance and commitment therapy. *Psychotherapy in Australia*, 12(4), 70.
- Harris, C.R., Jenkins, M., & Glaser, D. (2006). Gender Differences in Risk Assessment: Why do Women Take Fewer Risks than Men? *Judgment and Decision Making*, 1(1), 48-63.
- Hay, P., Loukas, A., & Philpott, A. (2005). Prevalence and characteristics of men with eating disorders in primary care: How do they compare to women and what features may aid in identification? *Primary Care and Community Psychiatry*, 10(1), 1-6.
- Health and Care Professions Council. (2016). *Guidance on conduct and ethics for students*. London: HCPC.

- Health and Care Professions Council. (2015). *Standards of Proficiency - practitioner psychologists*. London: HCPC.
- Heidegger, M. (1962). *Being and time*. New York: Harper & Row.
- Henwood, K.L., & Pidgeon, N.F. (1992). Qualitative research and psychological theorizing, *British Journal of Psychology* 83, 97-111.
- Hepworth, J. (1994). Qualitative analysis and eating disorders: Discourse analytic research on anorexia nervosa. *International Journal of Eating Disorders*, 15(2), 179–185.
- Hibbs, R., Rhind, C., Leppanen, J., & Treasure, J. (2015). Interventions for caregivers of someone with an eating disorder: A meta-analysis. *International Journal of Eating Disorders*, 48(4), 349-361.
- Hill, A.J., & Franklin, J.A. (1998). Mothers, Daughters and dieting: investigating the transmission of weight control. *British Journal Clinical Psychology*, 37, 3-13.
- Hill, L.S., Reid, F., Morgan, J.F., & Lacey, J.H. (2010). SCOFF, the development of an eating disorder screening questionnaire. *International Journal of Eating Disorders*, 43, 344-351.
- Hoetzel, K., von Brachel, R., Schlossmacher, L., & Vocks, S. (2013). Assessing motivation to change in eating disorders: a systematic review. *Journal of Eating Disorders*, 1,38.
- Holliday, J., Wall, E., Treasure, J., & Weinman, J. (2004). Perceptions of illness in individuals with anorexia nervosa: A comparison with lay men and women. *International Journal of Eating Disorders*, 37(1), 50-56.
- Hope, T., Tan, J., Stewart, A., & Fitzpatrick, R. (2011). Anorexia nervosa and the language of authenticity. *Hastings Center Report*, 41(6), 19-29.
- Horesh, N., Sommerfeld, E., Wolf, M., Zubery, E., & Zalsman, G. (2015). Father-daughter relationship and the severity of eating disorders. *European Psychiatry*, 30(1), 114-120.

- Hubble, M. A., Duncan, B. L., & Miller S. D. (1999). Introduction. In M.A. Hubble, B. L. Duncan, & S.D. Miller (Eds.), *The heart & soul of change: What works in therapy* (pp. 1-19). Washington, D. C.: American Psychological Association.
- Hurst, K., & Zimmer-Gembeck, M. (2015). Focus on perfectionism in female adolescent anorexia nervosa. *International Journal of Eating Disorders*, 48(7), 936-941.
- Husserl, E. (1931). *Ideas: General introduction to pure phenomenology*. London: Routledge.
- Husserl, E. (1964). *The idea of phenomenology*. The Hague: Martinus Nijhoff.
- Husserl, E. (1970). *Logical Investigations, Vol I* (J.N. Findlay, Trans.). London: Routledge and Kegan Paul.
- Jarman, M. Smith, J., & Walsh, S. (1997). The psychological battle for control: A qualitative study of health-care professionals' understandings of treatment of Anorexia Nervosa. *Journal of Community and Applied Psychology*, 7(2), 137-152.
- Jenkins, J., & Ogden, J. (2012). Becoming 'whole' again: A qualitative study of women's views of recovering from anorexia nervosa. *European eating disorders review*, 20(1).
- Johnson, A.G. (2005). *The Gender Knot: Unraveling our Patriarchal Legacy*. Philadelphia: Temple University Press.
- Johnson, J.L. (1997). Generalizability in qualitative research. *Excavating the discourse*. In J.M. Morse (Ed.) *Completing a Qualitative Project* (pp. 191-209.) London: Thousand Oaks.
- Johnson, S. (2017 October 11) Why don't men seek help for eating disorders?. *The Guardian*, Retrieved on 7<sup>th</sup> of February 2018.
- Jones, W., & Morgan, J. (2010). Eating disorders in men: A review of the literature. *Journal of Public Mental Health*, 9(2) 23-31.
- Juarascio, A., Shaw, J., Forman, E., Timko, C. A., Herbert, J., Butryn, M., . . . Lowe, M.

- (2013). Acceptance and commitment therapy as a novel treatment for eating disorders: An initial test of efficacy and mediation. *Behavior Modification*, 37(4), 459-489.
- Kahl, K.G., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioural therapies: what is new and what is effective? *Current Opinion in Psychiatry*, 25(6), 522-528.
- Kask, J., Ramklint, M., Kolia, N., Panagiotakos, D., Ekblom, A., Ekselius, L. & Papadopoulos, F.C. (2017). Anorexia Nervosa in males: excess mortality and psychiatric comorbidity in 609 Swedish in-patients. *Psychological Medicine*, 47(8) 1489-1499.
- Katzman, M. A., Hermans, K. M., van Hoeken, D., & Hoek, H. W. (2004). Not your “typical island woman”: Anorexia nervosa is reported only in subcultures in Curaçao. *Culture Medicine and Psychiatry*, 28, 463–492.
- Kaye, W.H., Bulik, C.M., Thornton, L., Barbarich, N., & Masters, K. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *American Journal of Psychiatry*, 161, 2215-2221.
- Keel, P.K., & Brown, T.A. (2010). Update on course and action in eating disorders. *International Journal of Eating Disorders*, 43, 195-2014.
- Kimmel, M.S. (1986). Introduction: toward men's studies, *American Behavioural Scientist*, 29(5), 517-529.
- Kindlon, D.J. & Thompson, M. (1999) *Raising Cain: Protecting the Emotional Life of Boys*. New York: Ballantines Reader Circle.
- Kirby, J. S., Runfola, C. D., Fischer, M., Baucom, D. H., & Bulik, C. M. (2015). Couple-Based Interventions for Adults with Eating Disorders. *Eating Disorders*, 23(4), 356–365.
- Kitson, C. (2012). Motivation to change. In, J.R.E. Fox & K.P. Goss (Eds.) *Eating and its Disorders* (pp. 75-101). Chichester: Wiley and Sons.
- Kolnes, L. (2016). 'Feelings stronger than reason': Conflicting experiences of exercise in women with anorexia nervosa. *Journal of Eating Disorders*, 4, 6.



- Kostro, K., Lerman, J.B., & Attia, E. (2014). The current status of suicide and self-injury in eating disorders: a narrative review. *Journal of Eating Disorders*, 2(1), 19-28.
- Kvale, S. (1996). *Interviews*. London: Sage.
- Laghi, F., Pompili, S., Zanna, V., Castiglioni, M. C., Criscuolo, M., Chianello, I., . . . & Baiocco, R. (2017). How adolescents with anorexia nervosa and their parents perceive family functioning? *Journal of Health Psychology*, 22(2), 197-207.
- Lamoureux, M. M., & Botorff, J. L. (2005). "Becoming the real me": Recovering from anorexia nervosa. *Health Care for Women International*, 26(2), 170-188.
- Lang, K., Lopez, C., Stahl, D., Tchanturia, K., & Treasure, J. (2014). Central coherence in eating disorders: An updated systematic review and meta-analysis. *World Journal of Biological Psychiatry*, 15(8), 586–598.
- Langenbach, M., & Subic-Wrana, C. (2009). Conscious and unconscious identification of female anorectic patients in in-patient psychotherapy. *Psychodynamic Practice*, 15(2), 147-159.
- Langley, J. (2006). *Boys get Anorexia Too: Coping with Male Eating Disorders in the Family*. London: Sage.
- Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In A. Thompson & D. Harper (Eds.), *Qualitative research methods in mental health and psychotherapy: a guide for students and practitioners* (pp. 99-116). Oxford: John Wiley & Sons.
- Larkin, M. Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3, 102-120.
- Latzer, Y., Hochdorf, Z., Bachar, E., & Canetti, L. (2002). Attachment style and family functioning as discriminating factors in eating disorders. *Contemporary Family Therapy*, 24, 581-598.
- Lavee, Y., Latzer, Y., & Gal, S. (2009). Marital and parent-child relationships in families with

- daughters who have eating disorders. *Journal of Family Issues*, 30, 1202-1220.
- Lee, C., Oliffe, J.L., Kelly, M.T., & Ferlatte, O. (2017). Depression and suicidality in gay men: Implications for health care providers. *American Journal of Men's Health*, 11(4), 910-911.
- Le Grange, D., Hoste, R.R., Lock, J., & Bryson, S.W. (2011). Parental expressed emotion of adolescents with anorexia nervosa: outcome in family-based treatment. *International Journal of Eating Disorders*, 44(8), 731–734.
- Le Grange, D., Loeb, J., Lock, K., & Nicholls, D. (2009). Academy for Eating Disorders position paper: the role of the family in eating disorders. *International Journal of Eating Disorders*, 43(1), 1-5.
- Leonidas, C., & Santos, M. A. (2015). Family relations in eating disorders: the Genogram as instrument of assessment. *Ciencia & saude coletiva*, 20(5), 1435-1447.
- Linardon, J., Fairburn, C.G., Fitzsimmons-Craft, E., Wilfley, D.E., Brennan, L. (2017). The empirical status of third wave behaviour therapies for the treatment of eating disorders: a systematic review. *Clinical Psychology Review*, 58, 125-140.
- Linehan, M. (1993). *Cognitive-Behaviour Treatment of Borderline Personality Disorder*. New York: The Guilford Press.
- Lock, A., Epston, D. & Maisel, R. (2005). Resisting anorexia/bulimia: Foucauldian perspectives in narrative therapy. *British Journal of Guidance and Counselling*, 33(3), 315-332.
- Løvoll, H.S., Røysamb, E., Vittersø, J., & Zourbanos, N. (2017). Experiences matter: Positive emotions facilitate intrinsic motivation, *Cogent Psychology*, 4:1. doi: 10.1080/23311908.2017.1340083
- Luck, A.J., Morgan, J.F., Reid, F., O'Brien, A., Brunton, J., Price, C., Perry, L., Lacey, J.H. (2002). The SCOFF questionnaire and clinical interview for eating disorders in general practice: Comparative study. *British Medical Journal*, 325(7367), 755–756.
- Lyons, A. C. (2009). Masculinities, femininities, behaviour and health. *Social and personality*

*psychology compass*, 3(4), 394-412.

Mabe, A., Forney, K., & Keel, P. (2014). Do you “like” my photo? Facebook use maintains eating disorder risk. *International Journal of Eating Disorders*, 47(5), 516-523. doi: <http://dx.doi.org.proxy.library.cmu.edu/10.1002/eat.22254>.

Machado, P.P.P., Gonçalves, S., & Hoek H.W. (2013). DSM-5 reduces the proportion of EDNOS cases: Evidence from community samples. *International Journal of Eating Disorders*, 46, 60-65.

MacLean, A., Sweeting, H., Walker, L., Patterson, C., Räisänen, U., & Hunt, K., (2015). “It’s not healthy and it’s decidedly not masculine”: a media analysis of UK newspaper representations of eating disorders in males. *BMJ Open*, 5, doi:10.1136/bmjopen-2014-007468.

Madhill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91, 1-20.

Mahalik, J.R., Burns, S.M., & Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Social Science & Medicine*, 64(11), 2201-2209.

Makino, M., Tsuboi, K., & Dennerstein, L. (2004). Prevalence of eating disorders: a comparison of western and non-western countries. *Medscape General Medicine*, 6(3):49.

Mallick, N., Ray, S., & Mukhopadhyay, S. (2014). Eating behaviours and body weight concerns among adolescent girls. *Advances in Public Health*, 2014, Article ID 257396. doi:10.1155/2014/257396.

Mander, J., Teufel, M., Keifenheim, K., Zipfel, S., & Giel, K.E. (2013). Stages of change, treatment outcome and therapeutic alliance in adult inpatients with chronic anorexia nervosa. *BMC Psychiatry*, 13(1), 111-118.

Marks, P., Beumont, P., & Birmingham, C.L. (2003). GPs managing patients with eating disorders. a tiered approach. *Australian Family Physician*, 32, 509-514.

- Marsh, S. (2017, July 31). Eating disorders in men rise by 70% in NHS figures. *The Guardian*. Retrieved from <https://www.theguardian.com/society/2017/jul/31/eating-disorders-in-men-rise-by-70-in-nhs-figures>.
- Martinez, E., Castro, J., Bigorra, A., Morer, A., Calvo, R., Vila, M., Toro, J., & Rieger, E. (2007). Assessing motivation to change in bulimia nervosa: the bulimia nervosa stages of change questionnaire. *European Eating Disorders Review*, 15(1), 13-23.
- Mason, J. (2018). *Qualitative Researching*. (Third ed.) London: Sage.
- Mason, J. (2002). *Qualitative Researching*. (Second ed.) London: Sage.
- May, A.L., Kim, J., McHale, S.M., & Crouter, A.C. (2006). Parent-adolescent relationships and the development of weight concerns from early to late adolescence. *International Journal of Eating Disorders*, 39(8), 729-740.
- McLachlan, S., & Hagger, M. S. (2011). Do people differentiate between intrinsic and extrinsic goals for physical activity?. *Journal of Sport and Exercise Psychology*, 33(2), 273-288.
- Micali, N., Hagberg, K.W., Petersen, I., & Treasure, J.L. (2013). The incidence of eating disorders in the UK in 2000–2009: Findings from the general practice research database. *BMJ Open*, 3(5). doi: 10.1136/bmjopen-2013-002646.
- Miller, R.L. (1999). *Enhancing Motivation for Change in Substance Abuse Treatment*. Treatment Improvement Protocol Series 35, U.S. Department of Health and Human Services.
- Miller, T. (2011). Falling back into gender? Men's narratives and practices around first-time fatherhood. *Sociology*, 45(6), 1094-1109.
- Miller, R.L. & Carroll, K. M. (2012). *Rethinking Substance Abuse: What Science Shows and what We Should Do About it*. London: The Guildford press.
- Miller, W. R., & Rollnick, S., (1952; 2002). *Motivational interviewing: Preparing people to change addictive behavior* (2nd ed.). New York: Guilford Press.

- Minuchin, S., Rosman, B., & Baker, L. (1978). *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge: Harvard University Press.
- Mitchison, D., & Mond, J.M. (2015). Epidemiology of eating disorders, eating disorders behaviour, and body image disturbance, in males: A narrative review. *Journal of Eating Disorders*, 3:20.
- Mond, J.M. (2013). Eating disorders as “brain-based mental illnesses”: An antidote to stigma? *Journal of Mental Health*, 22(1), 1-3.
- Moorhead, S. A., Hazlett, D. E., Harrison, L., Carroll, J. K., Irwin, A., & Hoving, C. (2013). A new dimension of health care: systematic review of the uses, benefits, and limitations of social media for health communication. *Journal of medical Internet research*, 15(4).
- Morgan, D.L. (1997). *Focus Groups as Qualitative Research*. Sage: London.
- Morgan, J.F., Reid, F., & Lacey, J.H. (1999). The SCOFF questionnaire: Assessment of a new screening tool for eating disorders. *BMJ*, 319(7223): 1467-1468.
- Moulding, N.T. (2015). Gendered intersubjectivities in narratives of recovery from an eating disorder. *Affilia: Journal of Women and Social Work*, 31(1), 70-83.
- Mulkerrin, Ú., Bamford, B., & Serpell, L. (2016). How well does anorexia nervosa fit with personal values? an exploratory study. *Journal of Eating Disorders*, 4(1), 20.
- Munro, C., Thomson, V., Corr, J., Randell, L., Davies, J.E., Gittoes, C., ...& Freeman, C.P. (2014) A new service model for the treatment of severe anorexia nervosa in the community: the anorexia nervosa intensive treatment team. *Psychiatric Bulletin*, 38(5), 220-225.
- Murakami, J. M., Essayli, J. H., & Latner, J. D. (2016). The relative stigmatization of eating disorders and obesity in males and females. *Appetite*, 102, 77-82.
- Nathanson, C. (1977) Sex roles as variables in preventive health behaviour *Journal of Community Health*, 3(2), 142-155.

National Health Service (2017). Building greater insight through qualitative research. *Bite-Size Guide to Patient Insight*. Retrieved from:  
<https://www.england.nhs.uk/wp-content/uploads/2017/04/bitesize-guide-qualitative-research.pdf>.

National Institute for Health and Care Excellence (2012). *Health inequalities and population health*. nice.org.uk/guidance/lgb4 Retrieved from:  
<https://www.nice.org.uk/advice/lgb4/resources/health-inequalities-and-population-health-1681147764421>

National Institute for Health and Care Excellence. (2017). *Eating Disorders: recognition and treatment* (NICE Guideline No. 69). Retrieved from:  
<https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#treating-anorexia-nervosa>

National Institute for Health and Care Excellence. (2017). *Eating Disorders: recognition and treatment* (NICE Guideline No. 69) Retrieved from:  
<https://www.nice.org.uk/guidance/ng69/chapter/Recommendations#identification-andassessment>.

Ng, M., Freeman, M.K., Fleming, T.D., Robinson, Dwyer-Lindgren, M., Thomson, L....Gakidou, E. (2014). Smoking prevalence and cigarette consumption in 187 countries, 1980-2012. *JAMA*, 311(2), 183-192.

Nichols, D., Fogarty, S., Hay, P. & Ramjan, L.M. (2016). Participatory action research for women with anorexia nervosa. *Nurse Researcher* 23(5), 26-30.

Nordbø, R. H. S., Espeset, E. M. S., Gulliksen, K. S., Skårderud, F., Geller, J., & Holte, A. (2012). Reluctance to recover in anorexia nervosa. *European Eating Disorders Review*, 20(1), 60-67.

Nordbø, R.H., Espeset, E.M. Gulliksen, K.S. Skårderud, F. & Holte, A. (2006). The meaning of self-starvation: Qualitative study of patients' perception of anorexia nervosa. *International Journal of Eating Disorders*, 39(7), 556-564.

- Nordbø, R., Gulliksen, K., Espeset, E., Skårderud, F., Geller, J., & Holte, A. (2008). Expanding the concept of motivation to change: The content of patients wish to recover from anorexia nervosa. *International Journal of Eating Disorders*, 41, 635-642.
- Olivardia, R., Pope Jr., H. G., Borowiecki III, J. J. & Cohane, G. H. (2004). Biceps and body image: the relationship between muscularity and self-esteem, depression, and eating disorder symptoms. *Psychology of Men & Masculinity*, 5(2), 112 - 120.
- Olivardia, R., Pope Jr., H.G., Hudson, J.I. (2000). Muscle Dysmorphia in Male Weightlifters: A Case-Control Study. *The American Journal of Psychiatry*, 157(8), 1291-1296.
- Owens, N. (2017). Men Boys, & Eating Disorders. [video file] *Panorama*, BBC One. Retrieved from <http://www.bbc.co.uk/programmes/b08zk03z>.
- “The Oxford English Dictionary” *Oxford Dictionaries*. Retrieved 11 December 2017. <https://en.oxforddictionaries.com/definition/obsession>.
- Oyserman, D., & Destin, M. (2010). Identity-based motivation: Implications for intervention. *The Counseling Psychologist*, 38(7), 1001–1043.
- Packer, M. (1989). Tracing the hermeneutic circle: Articulating an ontical study of moral conflicts. In M. Packer & R. Addison (Eds.), *Entering the circle: Hermeneutic investigation in psychology* (pp. 95-117). Albany, NY: SUNY Press.
- Paechter, C. (2003). Masculinities and femininities as communities of practice. *Women’s Studies International Forum*, 26(1), 69-77.
- Parker, I. (2004). Criteria for qualitative research in psychology. *Qualitative research in psychology*, 1(2), 95-106.
- Pauli, D., Aebi, M., Winkler Metzke, C., & Steinhausen, H. (2017). Motivation to change, coping, and self-esteem in adolescent anorexia nervosa: A validation study of the anorexia nervosa stages of change questionnaire (ANSOCQ). *Journal of Eating Disorders*, 5, 11.
- Paulson-Karlsson, G., & Nevonen, L. (2012). Anorexia nervosa: Treatment expectations – a

- qualitative study. *Journal of Multidisciplinary Healthcare*, 5, 169-177.
- Pearce, J.M.S. (2006). Sir William Whitley Gull (1816-1890). *European Neurology*, 55, 53-56.
- Peate, I. (2011). Dangerously misunderstood: Men and eating disorders. *British Journal of Healthcare Assistants* 5(8), 383-387.
- Peterssen, S., Johnsson, P., & Perselus, K.H. (2017). A Sisyphean task: experiences of perfectionism in patients with eating disorders. *Journal of Eating Disorders*, 5(1), doi: 10.1186/s40337-017-0136-4.
- Petrie, T.A., & McFarland, M.B. (2009). Men and muscles: The increasing objectification of the male body. In K. Beals, & J. Reel (Eds.), *The hidden faces of eating disorders and the body image* (pp. 39-61). Reston, VA: American Alliance for Health, Physical Education and Dance.
- Pettersen, G., Thune-Larsen, K.B., Wynn, R., & Rosvinge, J.H. (2013). Eating disorders: challenges in the later phases of the recovery process: a qualitative study of patients' experiences. *Scandinavian Journal of Caring Sciences*, 27, 92–98.
- Pettersen, G., Wallin, K., & Björk, T. (2016). How do males recover from eating disorders? An interview study. *BMJ Open*, 6. doi:10.1136/bmjopen-2015-010760
- Pietkiewicz, I., & Smith, J.A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research in psychology. *Psychology Journal*, 20 (1), 7-14.
- Pleck, J.H. (1987). *The Myth of Masculinity* (3rd ed.). Cambridge, MA: M.I.T. Press.
- Pollatos, O., Kurz, A., Albrecht, J., Schreder, T., Kleemann, A. M., Schöpf, V., . . . Schandry, R. (2008). Reduced perception of bodily signals in anorexia nervosa. *Eating Behaviors*, 9(4), 381-388. 10.1016/j.eatbeh.2008.02.001
- Price-Evans, K., & Treasure, J. (2011). The use of motivational interviewing in anorexia nervosa. *Child and Adolescent Mental Health*, 16(2) 65-70.



- Prochaska, J.O., & Di Clemente, C.C. (1982). Trans-theoretical therapy: toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice* 19(3), 276-288.
- Prochaska, J.O., & Di Clemente, C.C. (1992). Stages of change in the modification of problem behaviors. In M. Hersen, R.M. Eisler, & P. Miller (Eds.) *Progress on behavior modification* (pp. 184–214). Sycamore, IL: Sycamore.
- Prochaska, J.O., Velicer, W.F. (1997). The Transtheoretical Model of health behavior change. *American Journal of Health Promotion*, 12, 38-48.
- Pudge, E. L. (2017 August 20). Men, eating disorders and why gender matters. *The Huffington Post*. Retrieved from [http://www.huffingtonpost.co.uk/emma-louise-pudge/men-eating-disorders-and-\\_b\\_17773122.html](http://www.huffingtonpost.co.uk/emma-louise-pudge/men-eating-disorders-and-_b_17773122.html).
- Räisänen, U., & Hunt, K. (2014). The role of gendered constructions of eating disorders in delayed help-seeking in men: a qualitative interview study. *BMJ*, 4(4). doi: 10.1136/bmjopen-2013-004342.
- Rance N., Moller N.P., & Clarke V. (2017). “Eating disorders are not about food, they’re about life”: Client perspectives on anorexia nervosa treatment. *Journal of Health Psychology*, 22(5), 582-594.
- Raveori, A., Keski-Rahkonen, A., & Hoek, H.W. (2014). A review of eating disorders in males. *Current Opinion in Psychiatry*, 27(6), 426-430.
- Reid, M., Williams, S., & Burr, J. (2010). Perspectives on eating disorders and service provision: A qualitative study of healthcare professionals. *European Eating Disorders Review*, 18, 390-398.
- Rennie, D. L. (1994). Human science and counselling psychology: Closing the gap between research and practice. *Counselling Psychology Quarterly*, 7(3), 235-250.
- Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20, 392-411.

- Rice, K.G., & Stuart, J. (2010). Differentiating adaptive and maladaptive perfectionism on the MMPI-2 and MIPS revised. *Journal of Personality Assessment*, 92(2).
- Rieger, E., Touyz, S., Schotte, D., Beumont, P., Russell, J., Clarke, ... M., Griffiths, R. (2000). Development of an instrument to assess readiness to recover in anorexia nervosa. *International Journal of Eating Disorders*, 28(4) 387-396.
- Rieger, E., Touyz, S.W., & Beumont, P.J.V. (2002). The anorexia nervosa stages of change questionnaire (ANSCQ): information regarding its psychometric properties. *Journal of Eating Disorders*, 32(1) 24-38.
- Ritschel, L.A. Lim, N.E., Stewart, L.M. (2015). Transdiagnostic applications of DBT for adolescents and adults. *American Journal of Psychotherapy*, 69(2), 111-128.
- Robinson, T. E., & Berridge, K. C. (2003). Addiction. *Annual Review of Psychology*, 54, 25-53.
- Robinson, K.J., Mountford, V.A., & Sperlinger, D.J. (2012). Being men with eating disorders: Perspectives of male eating disorder service-users. *Journal of Health Psychology*, 18(2), 176-186.
- Rogers, C. (1961). *On Becoming a Person*. London: Constable & Robinson Ltd.
- Roncero, M., Belloch, A., Perpiñá, C., & Treasure, J. (2013). Ego-syntonicity and ego-dystonicity of eating-related intrusive thoughts in patients with eating disorders. *Psychiatry Research*, 208(1), 67-73.
- Royal College of Psychiatry (2014). *MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa* CR189. (2nd edn.) Retrieved from <http://www.rcpsych.ac.uk/files/pdfversion/CR189.pdf>
- Russell, T.A., Schmidt, U., Doherty, L., Young, V., Tchanturia, K. (2009). Aspects of social cognition in anorexia nervosa: affective and cognitive theory of mind. *Psychiatry Research*, 168(3), 181–185.
- Ryan, R.M., & Deci, E.L. (2000). Self-determination theory and the facilitation of

- Intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68-78.
- Ryan, R. M., Lynch, M. F., Vansteenkiste, M., & Deci, E. L. (2011). Motivation and autonomy in counseling, psychotherapy, and behavior change: A look at theory and practice. *The Counseling Psychologist*, 39(2), 193-260.
- Rycroft, C. (1968). *A Critical Dictionary of Psychoanalysis* (p. 41). Harmondsworth: Penguin Books Ltd.
- Sanchez, D.T., & Kwang, T. (2007). When the relationship becomes her: Revisiting women's concerns from a relationship contingency perspective. *Psychology of Women Quarterly*, 31(4), 401-414.
- Sassaroli, S., Bertelli, S., Decoppi, M., Crosina, M., Milos, G., & Ruggiero, G.M. (2005). Worry and eating disorders: A psychopathological association. *Eating Behaviors*, 6(4), 301-307.
- Schmit, S. E., & Bell, N. J. (2017). Close relationships and disordered eating: Partner perspectives. *Journal of Health Psychology*, 22(4), 434-445.  
10.1177/1359105315603478
- Serpell, L., Treasure, J., Teasdale, J., & Sullivan, V. (1999). Anorexia nervosa: friend or foe? *International Journal of Eating Disorders*, 25(2), 177-186.
- Silver, J. (2013). Narrative Psychology. In C. Willig (Ed.), *Introducing Qualitative Research in Psychology* (pp. 143-155). Maidenhead: McGraw-Hill.
- Silverman, D. (1997). *Qualitative research: Theory, method, and practice*. London: Thousand Oaks.
- Silverman, J.A. (1988). Richard Morton's second case of anorexia nervosa: Reverend Minister Steele and his son—an historical vignette. *The International Journal of Eating Disorders*, 7(3), 439-441.
- Skårderud, F. (2007). Shame and pride in anorexia nervosa: A qualitative descriptive study. *European Eating Disorders Review : The Journal of the Eating Disorders*

*Association, 15(2), 81-97.*

- Smith, V., Chouliara, Z., Morris, P.G., Collin, P., Power, K., Yellowlees, A., ... & Cook, M. (2016). The experience of specialist inpatient treatment for anorexia nervosa: A qualitative study from adult patients' perspectives. *Journal of Health Psychology, 21(1)*, 16–27.
- Smith, J.A. (1996) Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health, 11*, 261-271.
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review, 5(1)*, 9-27.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.
- Smith, J.A., & Osborn, M. (2003). Interpretative Phenomenological Analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (pp.51-80). London: Sage.
- 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)*, 251-268.
- Soenens, B., Vansteenkiste, M., Luyten, P., Duriez, B., & Goossens, L. (2005). Maladaptive perfectionistic self-representations: The mediational link between psychological control and adjustment. *Personality and Individual Differences, 38*, 487-498.
- Solmi, F., Hotopf, M., Hatch, S. L., Treasure, J., & Micali, N. (2015). Eating disorders in a multi-ethnic inner-city UK sample: prevalence, comorbidity and service use. *Social psychiatry and psychiatric epidemiology*, 1-13. doi: 10.1007/s00127-015-1146-7
- Spivack, A., & Willig, C. (2010). There is a battle within yourself: exploring the experience of a split sense of self among inpatients with eating disorders. *Counselling Psychology Review, 25(4)*, 7-19.

- Startup, H., Lavender, A., Oldershaw, A., Stott, R., Tchanturia, K., Treasure, J., Schmidt, U. (2013). Worry and rumination in anorexia nervosa. *Behavioural and Cognitive Psychotherapy*, 41, 301-316.
- Steinhausen, H.C. (2009). Outcome of eating disorders. *Eating Disorders and Obesity*, 18 (1), 225-242.
- Stoke, M. (2013, November 11). Anorexia: not just a 'women's illness'. *The Times*. Retrieved from <https://www.thetimes.co.uk/article/anorexia-not-just-a-womens-illness-snfrd527788>
- Stoltz, K., & Ashy, J.S. (2007). Perfectionism and lifestyle: Personality differences among adaptive perfectionists, maladaptive perfectionists, and nonperfectionists. *Journal of Individual Psychology*, 63(4).
- Striegel, R.H., Bedrosian, R., Wang, C., & Schwartz, S. (2012). Why men should be included in research on binge eating: results from a comparison of psychosocial impairment in men and women. *International Journal of Eating Disorders*, 45(2), 233-240.
- Striegel-Moore, R.H., Garvin, V., Dohm, F., & Rosenheck, R.A. (1999). Psychiatric comorbidity of eating disorders in men: a national study of hospitalized veterans. *International Journal of Eating Disorders*, 25(4), 399-404.
- Striegel-Moore, R.H., Rosselli, F., Perrin, N., DeBar, L., Wilson, G.T., May, A., & Kraemer, H.C. (2009). Gender Difference in the Prevalence of Eating Disorder Symptoms. *International Journal of Eating Disorders*, 42(5), 471-474.
- Striegel Weissman, R. & Bulik, C. (2007). Risk factors for eating disorders. *American Psychologist*, 62(3), 181-198.
- Strong, S.M., Williamson, D.A., Netemeyer, R.G., & Greer, J.H. (2001). Eating disorder symptoms and concerns differ as a function of gender and sexual orientation. *Journal of Social and Clinical Psychology*, 62, 252-260.
- Strother, E., Lemberg, R., Stanford, S.C., & Tuberville, D. (2012). Eating disorders in men: underdiagnosed, undertreated, misunderstood. *Eating Disorders*, 20(5), 346-355.

- Sutandar-Pinnock, K., Blake Woodside, D., Carter, J. C., Olmsted, M. P., & Kaplan, A. S. (2003). Perfectionism in anorexia nervosa: A 6–24-month follow-up study. *International Journal of Eating Disorders*, 33(2), 225-229.
- Sutton, S. (2001). Back to the drawing board? A review of applications of the transtheoretical model to substance use. *Addiction*, 96, 175–186.
- Sweeting, H., Walker, L., MacLean, A., Patterson, C., Räisänen, U., & Hunt, K. (2015). Prevalence of eating disorders in males: a review of rates reported in academic research and UK mass media. *International Journal of Men's Health*, 15(2), 86-112.
- Swinbourne, J., Hunt, C., Abbott, M., Russell, J., St Clare, T., & Touyz, S. (2012). The comorbidity between eating disorders and anxiety disorders: prevalence in an eating disorder sample and anxiety disorder sample. *Australian and New Zealand Journal of Psychiatry*, 46(31), 118-131.
- Symonds, T. (2017, July 31). I was neither female nor starving myself. So how was I anorexic? *The Guardian*. Retrieved from <https://www.theguardian.com/commentisfree/2017/jul/31/anorexic-male-patient-eating-disorders-ward>
- Tchanturia, K. (2015). *Brief Group Psychotherapy for Eating Disorders* (Ed.) (p.24). Hove: Routledge.
- Tchanturia, K. Davies, H., Roberts, M., Harrison, A., Nakazato, M, Schmidt, U.,... Morris, R. (2012)., Poor cognitive flexibility in eating disorders: examining the evidence using the Wisconsin Card Sorting task. *PLoS One*, 7(1), e28331. <https://dx.doi.org/10.1371/journal.pone.0028331>
- Tebes, J. K. (2005). Community science, philosophy of science, and the practice of research. *American journal of community psychology*, 35(3-4), 213-230.
- Thaler, L., Israel, M., Antunes, J.M., Sarin, S., Zuroff, D.C., & Steiger, H. (2016). An examination of the role of autonomous versus controlled motivation in predicting inpatient treatment outcome for anorexia nervosa. *International Journal of Eating Disorders*, 49(6), 626-629.

- Thapliyal, P., Mitchison, D., & Hay, P. (2017). Insights into the experiences of treatment for an eating disorder in men: a qualitative study of autobiographies. *Behavior Science*, 7(2), 38.
- Thibodeaux, J. (2014). Three versions of constructionism and their reliance on social conditions in social problems research. *Sociology*, 48(4), 829-837.
- Thomas, S. (2013, February 12). Eating disorders in young people are still widely misunderstood. Nuffield Department of Primary Care Health Sciences. Retrieved from:  
<https://www.phc.ox.ac.uk/news/eating-disorders-in-young-people-still-widely-misunderstood>
- Thompson, D. (2017 March/April). Men and boys get eating disorders too. *Men's Health*. Retrieved from  
<http://onlinelibrary.wiley.com/store/10.1002/tre.568/asset/tre568.pdf?v=1&t=jdcuyczj&s=470d8fafc121691a778bc52b2389d9cc764e6979>
- Tiggeman, M., Martins, Y., & Kirkbride, A. (2007). Oh to be lean and muscular: body image ideals in gay and heterosexual men. *Psychology of Men and Masculinity*, 8, 15-24.
- Tomkins, L., & Eatough, V. (2010). Reflecting on the use of IPA with focus groups: pitfalls and potentials. *Qualitative Research in Psychology*, 7(3), 244-262.
- Tozzi, F., Sullivan, P., Fear, J., McKenzie, J., & Bulik, C.M. (2003). Causes and recovery in anorexia nervosa: the patient's perspective. *International Journal of Eating Disorders*, 33(2), 143-154.
- Treasure, J., Katzman, M., Schmidt, U., Troop, N., Todd, G., & D'Silva, P. (1999). Engagement and outcome in the treatment of bulimia nervosa: First phase of a sequential design comparing motivation enhancement therapy and cognitive behavioural therapy. *Behaviour, Research and Therapy*, 37, 405-418.
- Treasure, J., Smith, G., & Crane, A. (2016). *Skills-based Learning for Caring for a Loved One with an Eating Disorder. The New Maudlsey Method*. London: Routledge.

- Treasure, J., Whitaker, W., Whitney, J., & Schmidt, U. (2005). Working with families of adults with anorexia nervosa. *Journal of Family Therapy*, 27, 158–170.
- Troop, N. A., & Redshaw, C. (2012). General shame and bodily shame in eating disorders: A 2.5-Year longitudinal study. *European Eating Disorders Review*, 20(5), 373-378.
- Tveiten, S., & Knutsen, I. R. (2011). Empowering dialogues – the patients' perspective. *Scandinavian Journal of Caring Sciences*, 25(2), 333-340.
- Vall, E., & Wade, T. (2015). Predictors of treatment outcome in individuals with eating disorders: a systematic review and meta-analysis. *International Journal of Eating Disorders*, 48(7), 946-971.
- Vallerand, R. J. (2008). On the psychology of passion: In search of what makes people's lives most worth living. *Canadian Psychology/Psychologie canadienne*, 49(1), 1-13.
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. New York: State of New York Press.
- Vansteenkiste, M., Soenens, B., & Vandereycken, W. (2005). Motivation to change in eating disorder patients: clarification on the basis of self-determination theory. *International Journal of Eating Disorders*, 37(3), 207-219.
- Vandereyken, W., & Vansteenkiste, M., (2009). Let eating disorder patients decide: providing choice may reduce early drop-out from inpatient treatment. *European Eating Disorders Review*, 17(3), 177-183.
- Verbrugge, L.M. (1985). Gender and health: an update on hypotheses and evidence *Journal of Health and Social Behaviour*, 26, 156-182.
- Vicary, S., Young, A., & Hicks, S. (2017). A reflective journal as learning process and contribution to quality and validity in Interpretative Phenomenological Analysis. *Qualitative Social Work*, 4(16), 550-565.
- Vygotsky, L. S. (1978). Interaction between learning and development. In M. Cole, V. John-Steiner, S. Scribner, & E. Souberman (Eds.), *Mind in society: The development of higher psychological processes* (pp. 79-91). Cambridge, MA: Harvard University



Press.

Villa, V., Manzoni, G.M., Pagnini, F., Castelnuovo, G., Cesa, G.L., Molinari, E. (2009). Do coping strategies discriminate eating disordered individuals better than eating disorder features? An explorative study on female inpatients with anorexia and bulimia nervosa. *Journal of Clinical Psychological Medical Settings*, 16, 297–303.

Vitousek K.B. (2005). Alienating patients from the “Anorexic Self”: Externalizing and related strategies. In Seventh International Conference on Eating Disorders. London.

Vitousek, K., Watson, S., & Wilson, G.T., (1998). Enhancing motivation to for change in treatment resistant eating disorders. *Clinical Psychology Review*, 18, 391-420.

Wade, T.D., Frayne, A., Edwards, S.A., Robertson, T., & Gilchrist, P. (2009). Motivational change in an inpatient anorexia nervosa population and implications for treatment. *Australian New Zealand Journal of Psychiatry*, 43(3), 235-243.

Waldman, A., Loomes, R., Mountford, V.A., & Tchanturia, K. (2013) Attitudinal and perceptual factors in body image distortion: an exploratory study in patients with anorexia nervosa. *Journal of Eating Disorders*, 1, 17.

Waller, G. (2011). The myths of motivation: Time for a fresh look at some received wisdom in the eating disorders?. *International Journal of Eating Disorders*, 45(1), 1-16.

Waller, H., Kennerley, H., & Ohanian, V. (2007). Schema-focussed cognitive behaviour therapy with eating disorders. In L.P. Riso, P.L. du Toit, D.E. Stein, & J.E. Young (eds.), *Cognitive Schemas and Core Beliefs in Psychological Problems: A Scientist Practitioner Guide* (pp.139–75). Washington, DC: American Psychiatric Association.

Walsh, B.T. (2013). The enigmatic persistence of anorexia nervosa. *American Journal of Psychiatry*, 170(5), 477–484.

Watson, H.J., & Bulik, C.M. (2013). Update on the treatment of anorexia nervosa: review of clinical trials, practice guidelines and emerging interventions. *Psychological Medicine*, 43(12), 2477–2500.

- Watzlawick, P., Beavin, J.H., & Jackson, D.D. (1967). *Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies and Paradoxes*. New York: Norton Books.
- Weinstein, N.D., Rothman, A.J., & Sutton, S.R. (1998). Stage theories of health behaviour: Conceptual and methodological issues. *Health Psychology, 17*, 290-299.
- Wells, A. (2000). Treating pathological worry and generalized anxiety disorder. *Emotional disorders and metacognition: Innovative cognitive therapy*, 155-178.
- West, R. (2005). Time for a change: putting the transtheoretical (stages of change) model to rest. *Addiction, 100*, 1036–1039.
- White, M. (2007). *Maps of narrative practice*. New York: W.W. Norton.
- White, M. (2011). *Narrative practice: continuing the conversations*. New York: W.W. Norton.
- Wildes, J.E., Ringham, R.M., & Marcus, M.D. (2010). Emotion avoidance in patients with anorexia nervosa: Initial test of functional model. *International Journal of Eating Disorders, 43*(5), 398-404.
- Willer, R., Rogalin, C., Conclon, B., & Wojnowicz, M.T. (2013). Overdoing gender: A test of the masculine overcompensation thesis. *American Journal of Sociology, 118*, 980-1022.
- Williams, K., King, J., & Fox, J. R. E. (2016). Sense of self and anorexia nervosa: A grounded theory. *Psychology and Psychotherapy: Theory, Research and Practice, 89*(2), 211-228.
- Williams, S., & Reid, M. (2012). “It’s like there are two people in my head”: A phenomenological exploration of anorexia nervosa and its relationship to the self. *Psychology and Health, 27*(7), 798-815.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory*. Buckingham: Open University Press.
- Willig, C. (2013). *Introducing Qualitative Research in Psychology*. Maidenhead: McGraw-Hill.

- Willig, C. (2015). Discourse Analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (chapter 7). London: Sage.
- Willig, C., & Stainton Rogers, W. (2017). *The Sage Handbook of Qualitative Research in Psychology*. London: Sage.
- Wilson, G.T., & Schlam, T.R. (2004). The transtheoretical model and motivational interviewing in the treatment of eating and weight disorders. *Clinical Psychology Review, 24*, 361-378.
- Wisniewski, L., & Kelly, E. (2003). The application of dialectical behavior therapy to the treatment of eating disorders. *Cognitive and Behavioral Practice, 10*, 131-138.
- Wooldridge, T., & Lytle, P. (2012). An Overview of Anorexia Nervosa in Males. *Eating Disorders, 20*(5), 368-378.
- World Health Organisation. (1992). ICD-10 Classifications of Mental and Behavioural Disorder: Clinical Descriptions and Diagnostic Guidelines. Geneva. World Health Organisation. Revised in 2016.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health, 15*, 215-228.
- Young, S., Touyz, S., Meyer, C., Arcelus, Rhodes, P., Madden, S.,...Hay, P. (2018). Relationships between compulsive exercise, quality of life, psychological distress and motivation to change in adults with anorexia nervosa. *Journal of Eating Disorders, 6*: 2.
- Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema Therapy: A Practitioner's Guide*. New York: Guilford Press.
- Zaitsoff, S.L. & Taylor, A. (2009). Factors Related to Motivation for Change in Adolescents with Eating Disorders. *European Eating Disorders Review, 17*, 227-233.
- Zak-Hunter, L., & Johnson, L.N. (2015). Exploring the association between partner

behaviors and eating disorder symptomology. *Family Medicine and Community Health*, 33(4), 405-409.

Zerwas, S., Larsen, J.T., Petersen, L., Thornton, L.M., Mortensen, P.B., & Bulik, C.M., (2015). The incidence of eating disorders in a Danish register study: Association with suicide risk and mortality. *Journal of Psychiatric Research*, 65, 16-22.

## **7. Appendices**

### **7.1. Anorexia Nervosa Diagnostic Criteria**

According to the DSM 5, to be diagnosed as having Anorexia Nervosa a person must display:

- i. Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health) .
- ii. Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
- ii. Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Subtypes:

Restricting type

Binge-eating/purging type

## 7.2. Recruitment Advertisement



**Department of Psychology  
City University London**

**PARTICIPANTS NEEDED FOR  
RESEARCH ON *MEN'S EXPERIENCES OF RECOVERING FROM ANOREXIA NERVOSA***

We are looking for volunteers to take part in a study on men's experience of motivation to change in relation to their recovery from Anorexia Nervosa.

You would be asked to:  
complete a brief anonymous demographic questionnaire  
and taking part in a confidential and anonymous interview.

Your participation would involve 1 session (2 at the most),  
each of which is approximately 60-90 minutes.

In appreciation for your time, your travel and food expenses will be refunded.

For more information about this study, or to take part,  
please contact:  
*The researcher Barbara Tresca or the research supervisor Dr Susan Strauss*

Psychology Department  
at  
020 7040 or  
Email: [REDACTED]

Or [REDACTED]

This study has been reviewed by, and received ethics clearance through the Research Ethics Committee, City University London. If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [REDACTED] or via email: [REDACTED]

### 7.3. Ethics Approval (City, University of London)



Psychology Research Ethics Committee  
School of Arts and Social Sciences  
City University London  
London EC1R 0JD

23<sup>rd</sup> November 2015

Dear Barbara Tresca

**Reference:** PSYETH (P/F) 15/16 32

**Project title:** Men's experiences of motivation to change in relation to their progression through Anorexia Nervosa.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

#### Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

#### Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

- (a) Recruit a new category of participants
- (b) Change, or add to, the research method employed
- (c) Collect additional types of data
- (d) Change the researchers involved in the project

#### Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [REDACTED] in the event of any of the following:

- (a) Adverse events
- (b) Breaches of confidentiality
- (c) Safeguarding issues relating to children and vulnerable adults
- (d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event.

Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Hayley Glasford  
Student Administrator  
Email: [REDACTED]

Katy Tapper  
Chair  
[REDACTED]

#### 7.4. Approval of Amendments to Ethics Form (City, University of London)



### Psychology Department Research Ethics Committee

#### Project Amendments/Modifications Request for Extension

*For use in the case of all research previously approved by City University London Psychology Department Research Ethics Committee.*

**Was the original application reviewed by light touch?**

If yes, please send this form to the individual who reviewed the original application. Once they have approved the amendment and signed the form, it should be emailed to [psychology.ethics@city.ac.uk](mailto:psychology.ethics@city.ac.uk)

**Was the original application reviewed at a full committee meeting?**

If yes, please email this form to [psychology.ethics@city.ac.uk](mailto:psychology.ethics@city.ac.uk). It will be reviewed by the committee chair.

*Note that you only have to respond to the sections relevant to you.*

#### Details of Principal Investigator and Study

Name	Barbara Tresca
Email	
Title of study	Men's experiences of motivation to change in relation to their progression through Anorexia Nervosa.
REC reference number	PSYETH (P/F) 15/16 32

#### Study Duration

Start Date	2015
End Date	2017

#### Project Amendments / Modifications

**Type of modification/s** (tick as appropriate)

Research procedure/protocol (including research instruments)	X
Participation group	
Information Sheet/s	X
Consent form/s	X
Other recruitment documents	
Sponsorship/collaborations	
Principal investigator/supervisor	
Extension to approval needed (extensions are given for one year)	
Other	

**Details of modification** (give details of each of the amendments requested, state where the changes have been made and attach all amended and new documentation)

--



1. Recruitment via Facebook using the poster that has already been approved by the ethics Committee in December 2015 (please find attached). The poster will be used as a Facebook page online. In order to prevent confidentiality or privacy concerns individuals will not be able to interact on the Facebook page, as it will only serve as an advertisement page.
2. Face-to-face interviews carried out via skype (Please see the modified information sheet and consent form).

**Justify why the amendment/extension is needed** (including the period of extension being requested)

- Recruitment online via Facebook might help speed up the process of finding men who have an experience of Anorexia Nervosa, as it opens the recruitment to other channels. Some men who had this experience may not be in touch with charities or organisations which directly support people with this eating disorder so online recruitment might be helpful to find other participants.
- Face-to-face interviews in person might sometimes be a complicated process for 2 reasons: some potential participants live in Scotland or Ireland which would be too expensive to refund for the transport. Moreover, it would allow me to interview participants if I have to go to abroad for family emergency. I have had to take a month off in Italy recently as my father was unexpectedly very ill.

**Period of extension requested**

n/a

**Other information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes)

n/a

**Change in the study team**

**Staff member**

<i>Title, Name &amp; Staff Number</i>	<i>Post</i>	<i>Dept &amp; School</i>	<i>Phone</i>	<i>Email</i>	<i>Date and type of CRB disclosure*</i>

**Student**

<i>Name &amp; Student Number</i>	<i>Course / Year</i>	<i>Dept &amp; School</i>	<i>Date and type of CRB disclosure*</i>

**External co-investigator/s**

<i>Title &amp; Name</i>	<i>Post</i>	<i>Institution</i>	<i>Phone</i>	<i>Email</i>	<i>Date and type of CRB disclosure*</i>

**Declaration** (to be signed by the Principal Investigator)

- I certify that to the best of my knowledge the information given above, together with any accompanying information, is complete and correct and I take full responsibility for it.

<b>Principal Investigator(s)</b> (student and supervisor if student project)	Barbara Tresca	
<b>Date</b>	13.06.2016	

**Reviewer signature**

To be completed upon FINAL approval of the amendment.

	<b>Signature</b> (Please type name)	<b>Date</b>
<b>Reviewer</b>	Katy Tapper	14 <sup>th</sup> June 2016



**Psychology Department Research Ethics Committee**

**Project Amendments/Modifications  
Request for Extension**

*For use in the case of all research previously approved by City University London Psychology Department Research Ethics Committee.*

**Was the original application reviewed by light touch?**

If yes, please send this form to the individual who reviewed the original application. Once they have approved the amendment and signed the form, it should be emailed to [psychology.ethics@city.ac.uk](mailto:psychology.ethics@city.ac.uk)

**Was the original application reviewed at a full committee meeting?**

If yes, please email this form to [psychology.ethics@city.ac.uk](mailto:psychology.ethics@city.ac.uk). It will be reviewed by the committee chair.

*Note that you only have to respond to the sections relevant to you.*

**Details of Principal Investigator and Study**

<b>Name</b>	Barbara Tresca
<b>Email</b>	

Title of study	Men's experiences of motivation to change in relation to their progression through Anorexia Nervosa.
REC reference number	PSYETH (P/F) 15/16 32

#### Study Duration

Start Date	2015
End Date	2017

#### Project Amendments / Modifications

**Type of modification/s** (tick as appropriate)

Research procedure/protocol (including research instruments)	X
Participation group	
Information Sheet/s	
Consent form/s	
Other recruitment documents	
Sponsorship/collaborations	
Principal investigator/supervisor	
Extension to approval needed (extensions are given for one year)	
Other	

**Details of modification** (give details of each of the amendments requested, state where the changes have been made and attach all amended and new documentation)

#### 3. Recruitment of English speaking men extended to non UK countries.

**Justify why the amendment/extension is needed** (including the period of extension being requested)

- A large part of the potential participants who volunteered to take part in the research study are English speaking men who do not reside in the UK. This is because recruitment is, and has been, carried out also using online means, through organisations like *Men Get Eating Disorders Too* and *B-EAT*. Since the male population who experienced Anorexia Nervosa, and willing to share their experience appears to be limited and relatively difficult to reach, it would be considerably advantageous to allow people who live outside the UK to be recruited and interviewed remotely.

**Period of extension requested**

n/a

**Other information** (provide any other information which you believe should be taken into account during ethical review of the proposed changes)

n/a

**Change in the study team**

**Staff member**

Title, Name & Staff Number	Post	Dept & School	Phone	Email	Date and type of CRB disclosure*
n/a					

--	--	--	--	--	--

**Student**

<i>Name &amp; Student Number</i>	<i>Course / Year</i>	<i>Dept &amp; School</i>	<i>Date and type of CRB disclosure*</i>
n/a			

**External co-investigator/s**

<i>Title &amp; Name</i>	<i>Post</i>	<i>Institution</i>	<i>Phone</i>	<i>Email</i>	<i>Date and type of CRB disclosure*</i>
n/a					

**Declaration** (to be signed by the Principal Investigator)

- I certify that to the best of my knowledge the information given above, together with any accompanying information, is complete and correct and I take full responsibility for it.

<b>Principal Investigator(s)</b> (student and supervisor if student project)	Barbara Tresca	Susan Strauss
<b>Date</b>	17.08.2016	

**Reviewer signature**

To be completed upon FINAL approval of the amendment.

	<b>Signature</b> (Please type name)	<b>Date</b>
<b>Reviewer</b> Martin Conway, HoD		18/08/2016

## 7.5. Participant Information Sheet



**Title of study** *Men's Experiences of Motivation to Change in Relation to their progression through Anorexia Nervosa.*

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

### **What is the purpose of the study?**

The purpose of this study is to explore men's experiences of motivation to change in relation to their progression through Anorexia Nervosa. The aim is to understand the feelings and/or perceptions of your lived experience. The study is undertaken as part of a Professional Doctorate in Counselling Psychology programme.

### **Why have I been invited?**

You had an experience of living with Anorexia Nervosa in the past and currently have a BMI of 17.5 or above. You will have been recruited through posters in Mental Health charities, such as Mind, Eating Disorders' organisations, academic institutions, online, or through word of mouth.

### **Do I have to take part?**

Participation in the project is voluntary. You can choose not to participate in part or all of the project.

If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw within 3 months from the interview and without giving a reason or being penalized or disadvantaged in any way.

### **What will happen if I take part?**

You will first take part in a semi-structured interview and then you will be asked if you want to respond to a brief set of demographical questions such as your age, sex, ethnicity, marital status, employment status and education.

After the interview you will be invited to share reflections and or considerations. You will then be thanked for your participation and debriefed. Moreover, you will be provided with contacts of organisations which offer adequate support should you feel distressed or the need to further explore your feelings and thoughts. This study involves interviewing 6 – 8 participants.

Interviews will take place in a quiet, private location such as a hired room at university, or a hired private counselling room. Alternatively, interviews may take place online via Skype. For further information on security of Skype, please see <https://www.skype.com/en/security/>.

After the first audio recorded interview, the researcher may ask you to meet again. However, you can choose whether to give permission or not to the second interview.

Each meeting with the researcher will last no longer than 2 hours (expected duration is between 1 and 2 hours).

The research will use a qualitative method. The data collection and analysis is informed by interpretative phenomenological analysis: through your accounts, the researcher's interest focuses on your experience within the surrounding environment.

### **Expenses and Payments**

Travel expenses will be paid for by the researcher within limits and depending on circumstances which can be discussed over email/phone (usually up to £30).

### **What you have to do**

You will be asked to answer the researcher's interview questions as honestly and clearly as you feel comfortable doing.

### **What are the possible disadvantages and risks of taking part?**

You could feel particularly sensitive, or have heightened feelings during or after the interview. Should this occur please discuss this with the researcher as she can refer you to appropriate services.

**What are the possible benefits of taking part?**

You may find it useful to participate in this project, as this may be beneficial for your exploration and understanding of your experiences. While taking part will contribute to raising the awareness of your experiences it may improve the development of treatment and care plans, therefore helping future patients, as well as their carers, parents, doctors, counsellors, support teams.

**What will happen when the research study stops?**

If the project is stopped permanently your data will be destroyed immediately. If the study is provisionally suspended the data will be stored for a maximum of 5 years. If data are to be published data will be stored for 5 years when the research ends at its natural ending point.

**Will my taking part in the study be kept confidential?**

The researcher will only have access to the information before anonymising the data.

After the Audio-recording's successful transfer from the Dictaphone to the laptop, the file on the Dictaphone will be destroyed. The audio-files will be kept confidential on a double password protected file on a password protected laptop.

Personal information will be kept strictly confidential by the researcher during the research phase and no third parties will have access to it, throughout and after the study is completed. It will be protected by a double e coding system and stored on a password protected laptop computer. Personal information will be destroyed at the end of the study. Personal data will not be shared with third parties.

There are restrictions to confidentiality: Should the researcher feel that your life is currently in danger, or someone else's life is at risk due to self-inflicted harm or harm from others, she will discuss this with you and the supervisor and may have to report this to authorities.

**What will happen to the results of the research study?**

After the study's completion, the thesis will be part of the British Library's and University's theses database and will be accessible to the public. At present, it is not possible to predict whether this study will be published and in what form it might be published. Confidentiality will be maintained at all times. Should you be interested in receiving a copy of the publication or a summary of the publication please contact the researcher or London City University.

**What will happen if I don't want to carry on with the study?**

You are free to withdraw from the study without an explanation or penalty up to 3 months after the interview.

**What if there is a problem?**

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you should phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: *Men's Experiences of Motivation to Change in Relation to their Progression through Anorexia Nervosa*.

You could also write to the Secretary at:

Anna Ramberg  
Secretary to Senate Research Ethics Committee  
Research Office, E214  
City University London  
Northampton Square  
London  
EC1V 0HB  
Email: [REDACTED]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

**Who has reviewed the study?**

This study has been approved by City University London Psychology Research Ethics Committee, PSYETH (P/F) 15/16 32

**Further information and contact details**

Researcher : Barbara Tresca	email: [REDACTED]
Supervisor : Dr Susan Strauss	email: [REDACTED]

Thank you for taking the time to read this information sheet.



## 7.6. Consent Form

Title of Study: *Men's Experiences of Motivation to Change in Relation to their Progression through Anorexia Nervosa.*

Ethics approval code: PSYETH (P/F) 15/16 32

Please initial box

1.	<p>I agree to take part in the above City, University of London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.</p> <p>I understand this will involve:</p> <ul style="list-style-type: none"> <li>• being interviewed by the researcher</li> <li>• allowing the interview to be audiotaped</li> <li>• completing a questionnaire asking me about general demographic information such as age, employment, education, marital status.</li> <li>• making myself available for a further interview should that be required</li> </ul>	
2.	<p>This information will be held and processed for the following purpose(s):</p> <p><i>To answer the research questions.</i></p> <p>I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.</p> <p>I understand that my given name will be substituted by a pseudonym to protect my identity. Other names, places, dates, third parties names' mentioned during the interview, will also be changed, added or deleted to confound information in order to protect my identity from being made public.</p> <p>I understand that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research.</p>	
3.	<p>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.</p>	
4.	<p>I agree to City University London recording and processing this information about me. I understand that this information</p>	

	will be used only for the purpose set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

\_\_\_\_\_  
Name of Participant                      Signature                      Date

\_\_\_\_\_  
Name of Researcher                      Signature                      Date

When completed, 1 copy for participant; 1 copy for researcher file.

---

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

## 7.7. Debrief



### MEN'S EXPERIENCES OF MOTIVATION TO CHANGE IN RELATION TO THEIR PROGRESSION THROUGH ANOREXIA NERVOSA

#### DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished, what follows is a bit about the research. The purpose of this study is to explore men's experiences of motivation to change in relation to their progression through Anorexia Nervosa (AN). The aim is to investigate the depth and complexities of the experiences, therefore the feelings and perceptions of each participant's lived experience. The demographic questions at the end of the interview and the semi-structured interview you completed and took part in provided the data for collection for analysis. The accounts and subsequent interpretation of lived experiences will hopefully increase awareness of motivation to change related to the journey of AN for males.

Furthermore, your experience may contribute to the development of evidence based treatments and interventions for AN. This study hopes to add to the existing body of literature with regards to the experience of eating disorders in men and to the rejection of certain stereotypes associated with it.

If you feel uncomfortable, worried, or in any unusual state you may want to get in touch with the researcher and/or personal counsellor to discuss your concerns. Furthermore, you may wish to contact the following support organisations:

<i>Organisation</i>	<i>Number</i>	<i>Email / Website</i>
<u><i>UK</i></u>		
<i>Anorexia and Bulimia Care</i>	03000111213	support@anorexiabulimiacare.org.uk
<i>BEAT Beating Eating Disorders</i>	0345 634 1414	help@b-eat.co.uk
<i>MGEDT</i>	<i>n/a</i>	sam@mengetedstoo.co.uk
<i>Mind</i>	0300 123 3393	info@mind.org.uk
<i>Samaritans</i>	08457 90 90 90	<a href="http://jo@samaritans.com">jo@samaritans.com</a>
<u><i>Canada</i></u>		
<i>Looking Glass Foundation</i>	604 314 0548	info@lookingglassbc.com
<i>NEDIC</i>	1 866 633 4220	<i>n/a</i>

France

Anorexie et Boulimie	n/a	<a href="http://anorexie-et-boulimie.fr">anorexie-et-boulimie.fr</a>
Anorexie Boulimie Afdas	n/a	<a href="http://anorexiéboulimie-afdas.fr">anorexiéboulimie-afdas.fr</a>

Italy

ABA	800 16 56 16	<a href="mailto:info@bulimianoressia.it">info@bulimianoressia.it</a>
AIDAP	0458103915	<a href="mailto:info@aidap.org">info@aidap.org</a>

USA

ANAD	630 5771330	<a href="mailto:hello@anad.org">hello@anad.org</a>
NEDA	1 800 931 2237	text 'NEDA' to 741741 (crisis)

We hope you found the study interesting. If you have any other questions please do not Hesitate to contact us at the following:

Researcher: *Barbara Tresca*  
Supervisor: *Dr Susan Strauss*

email: [REDACTED]  
email: [REDACTED]

Ethics approval code: PSYETH (P/F) 15/16 32

## 7.8. Interview Schedule

### *Interview Questions*

- We were talking about the aim of the research earlier, to explore the experience of males' motivation to change in anorexia nervosa, I was wondering whether we could use your decision to take part as a starting point today, i.e. what motivated you to participate in this study?
- Given your experience of AN and your decision to take part in this study, I'm wondering where you feel would be a good point to start and discuss motivation to change in your journey.
- Do you remember if there was something, someone that influenced your motivation at the beginning of your journey in AN?

Prompt: Was there any difference later on in your journey?

- Can you remember whether people or the environment influenced your feelings towards your condition?
- Do you feel you made some changes?

Prompt: If so, would you relate these to your motivation to change?

Prompt: Could you describe this changes?

Prompt: As you think of your motivation to change at the time, were there activities you recall, which played a role in your will to make a change?

Prompt: Could you describe any physical sensations which you can remember from that time?

Prompt: Could you describe any reactions you may have had which to you may signify your motivation to change?

- What supported you at this point of change?

Prompt: Did you make others aware of this?

Prompt: Could you explain why?

### *Demographical Questionnaire*

Age:

Sex at birth:

Ethnicity:

Marital Status:

Do you have children?

Level of Education:

Educational background:

Which best describes your current circumstances? Fulltime employed, Part time employed, Student, Unemployed, Benefits (please circle)

## 7.9. Sample of Transcript and Layout

397	I20: No. No it- it varies a lot. It varied a	
398	lot and different things mattered at	
399	different times and I was more or less	
400	motivated at different times. <u>Ehm...</u> so –	
401	and often it's not sort of simply one	
402	thing's that's motivating me and another	
403	thing at another. So, there's always been	
404	to greater or less extent a fear of, a fear	
405	of being seen to fail. So part of what I	
406	was thinking when I was restricting was-	
407	<u>ehm...</u> that I couldn't stop restricting,	
408	because if I stopped restricting I'd put	
409	the weight back on and then I'd be seen,	
410	that would be a clear failure. And then	
411	going, as I was talking about earlier,	
412	once I got in the position of being more	
413	open to people that I had a problem and	
414	I was trying to recover, then I had to not	
415	be seen to fail and then also in recovery	
416	you- you form quite, I formed quite	

## 7.10. Sample of Analysis: Note-taking and Colour coding.

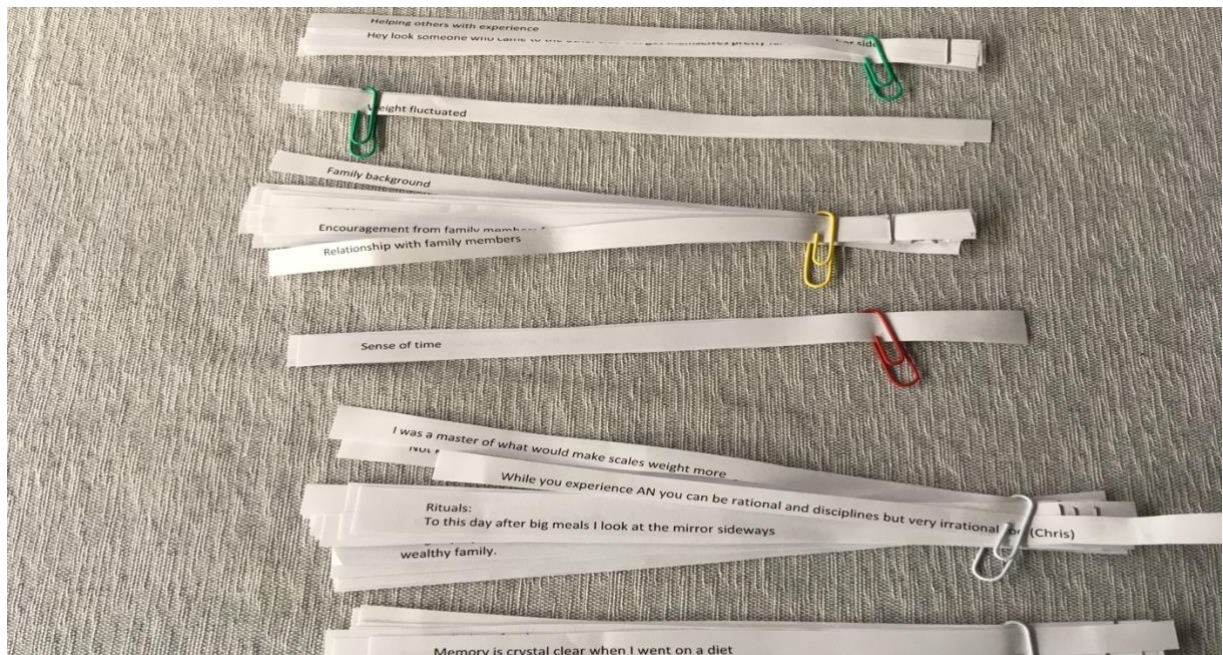
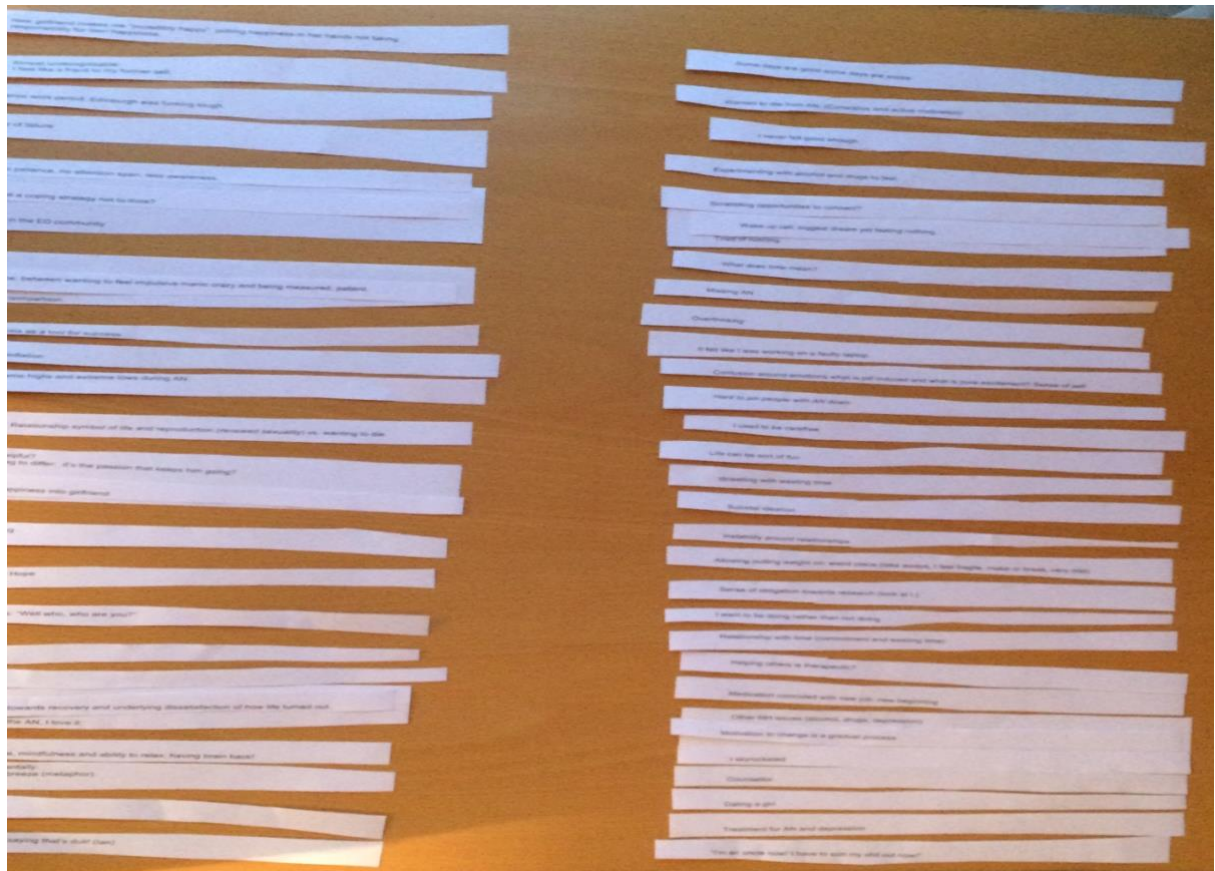
	553	R33: Do you think that this experience of your	
	554	seesaw, do you think it has changed over the	
	555	years?	
I'm trying to re-invent myself: no option besides starting over.	556	I33: Yeah, I don't, I don't think I'm the same as I	He thinks he has
	557	was <u>ehm</u> , now it's just, it's different I've sort of	changed as a person.
	558	kind of, what I'm trying to do is re-invent myself	He is trying to <i>reinvent</i>
	559	sort of change, start over because I, there really	<i>himself, start over</i> . No
	560	wasn't any other option besides just really	other options.
	561	starting over ah, you know things had gone such	
	562	a bad place for me personally that not everybody	I'm much different
	563	knows all the ins and outs of really what went	now and have happier
	564	on, of what happened eh, it just eh, yeah, it's	experiences than when
	565	much different now and I definitely have happier	

13

	105	my 20s I had similar periods. When I	
	106	turned 30 for similar reasons which we	AN impact on life, as a
	107	may or may not want to get to it sort of	precursor to seek help.
	108	went from being something I lived with to	<i>restricting</i>
	109	I suppose the reason I started <b>restricting</b>	<i>Not feeling</i>
	110	sort of for a few <b>years Anorexia became</b>	
	111	<b>almost the essential fact in my life.</b> The	Numb in situations
	112	sort of restricting, losing weight and all	which he remembered
	113	that. And I got to start off 2010, to April	being very sensitive to.,
	114	2013 I sort of had known for over a year	e.g. rugby game and
	115	that I had a problem, <b>and it was more</b>	theatre. <u>Wake up call?</u>
	116	<b>than my normal issues</b> and it took me	<i>More than Normal</i>
	117	that long to get the... <b>to get the strength</b>	<i>issues</i> – pushed
	118	<b>to go to my GP</b> and (pause) - and it was	towards GP.
	119	partly because it was something that	In this way quite a
	120	would really impact on – actually thinking	typical bloke.
	121	about it, it was 2 things: 1. I <b>just got to</b>	<u>Otherwise not?</u>
	122	<b>the stage of depression where I was</b>	
	123	<b>probably not helped by restricting, that I</b>	Dates are clear in mind.
	124	<b>just didn't feel anything anymore.</b> So I'm	
	125	a rugby fan, and I remember being at a	
Evolution of the ED from AN into binge-purge			
Self-deception			
Getting help from ED service			
Disclosure others: professional context.			
Fluctuations in recovery			



## 7.11. Sample of Analysis: Theme Clustering



## 7.12. Sample of Analysis stage: Table of Themes

### Recovering and Motivation

Distraction	"Distractions to get a positive momentum" "I need to learn to catch myself"	
Unrelenting standards and self-control, self-doubt	"Am I even going to be good at this?" "I want to do it my way, but my way is not working" "I'm never going to get there"	
The beginning of the end – motivation	"It's very difficult, I started to get it eventually" "I'm coming out" "I'm trying to re-invent myself: no options besides starting over"	

### 7.13. Table of Theme Recurrences

Master Theme	Sub-Theme	Daniel	Edward	Liam	Nick	Oscar	Matt	Wes	William
Sense of control		X	X	X	X	X	X	X	X
	The "constant" worry	X	X		X				X
	Fear of failure	X		X	X		X	X	X
	Controlled awareness		X	X	X		X		X
Me and the world	Letting go	X	X		X	X		X	X
		X	X	X	X	X	X	X	X
	Romantic relationships	X	X	X		X	X		
	Parent-son relationship	X		X	X	X	X	X	X
	Sense of Shame and Loneliness	X		X	X		X		X
Connecting		X	X	X	X	X	X	X	X
	Changing awareness	X	X						
	Coming clean	X	X	X	X	X	X	X	X
	Reflecting on motivation and recovery	X	X	X	X		X	X	X

**The Professional Practice Component of this thesis has been  
removed for confidentiality purposes.**

**It can be consulted by Psychology researchers on application at  
the Library of City, University of London.**

**The full text of this article has been  
removed for copyright reasons**