

Gendered experiences of living with eating disorders

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Portfolio submitted in fulfilment of the requirements for the
Professional Doctorate in Counselling Psychology (D.Psych)

City, University of London
Department of Psychology
September 2017



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Acknowledgements

First and foremost, I would like to express my profound gratitude to the participants in my research study and my case study. Although they must remain anonymous, should they ever read this thesis they may recognise their words and the names I have associated with them. So, to “Alice”, “Clive”, “Gareth”, “Jack”, “Jo”, “Luke”, “Mark”, “Michael” and “Peter”, I would like to say thank you. I have the deepest respect for your courage in the face of living with your eating disorders, your trust in me and the openness that you showed in telling me of your experiences. I hope that I have done you justice in this work.

These participants would not have been secured without the help of Men Get Eating Disorders Too (MGEDT), and B-EAT, the two charities that helped me with recruitment. I would particularly like to thank Sam Thomas, the founder of MGEDT, for going the extra mile in helping me to find the people I needed.

I would like to extend my deepest thanks to my supervisor, Dr Courtney Raspin, for her wisdom, encouragement and (when required) tough love during the writing of this thesis. Events turned this into the hardest period of my life, and without her support I would not have completed this work. I would also like to thank my course director, Dr Jessica Jones Nielsen, and my personal tutor, Dr Kate Scruby, for their advice and support at this time, and the Faculty for the understanding and flexibility that they showed me.

I owe a debt of gratitude to my clinical supervisors, David Chandler, Vanessa Roberts, and Dr Gislene Wolfart. I would particularly like to thank Dr Andre Geel for his trust in me, and the care he showed in allowing me to continue to work with him at a time of personal crisis.

Last, but by no means least, I would like to thank my friends and family. In particular, the Rev Dr Hugh Jones for steering me in the right psychological direction and

Acknowledgements

for the (now permanent!) loan of his psychology library; Gina Tenquist for helping me get it all to add up; Farah Mitha for her friendship, professional wisdom and encouragement; Dr Niah Wilson for blazing the trail, and for her Antipodean support and friendship while the rest of this hemisphere slept; and all my fellow students at City, University of London, and Nottingham Trent University. To Caroline and Gary for amazing food, lodging and fellowship. Finally, to my wife, Elizabeth Clarke, for supporting me through yet another degree; my mother for her unfailing love and support; my daughter Lucy for being a beacon of joy and light; and my daughter Emily for the inspiration she continues to give me.

Declaration of powers of discretion

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*He's grown his right thumb-nail to open bottles.
It's weird and witchy. A two-inch yellowing spade.
From out his denim waistcoat he takes
A twisty-wrapped sweet, and drawls,
"For Emily wherever I may find her!"*

(From "Louisiana Tony", unpublished poem by Emily Stiff).

For Emily, wherever I may find her.

Introduction to portfolio

This doctoral portfolio opens with an empirical piece of research examining men's lived experiences of binge eating and compensatory behaviours (BECB): men who, based on self-report, have met the diagnostic criteria for bulimia nervosa (BN) but may never have received a formal diagnosis. It proceeds to a case study of a young woman with anorexia nervosa (AN), referred to a community eating-disorder (ED) service for treatment using Cognitive Behavioural Therapy for Eating Disorders (CBT-E). It concludes with a publishable paper based on the research, intended for submission to *Counselling Psychology Review*.

I am aware that the first paragraph of this portfolio introduces several contradictions: My research is based on a male study group, and yet my case study is of a woman. It focusses on BN while the case study features AN. My research methodology employs interpretative phenomenological analysis (IPA), belonging to an interpretivist school of thought, whereas CBT would appear to be more positivist in its approach. I make no apology for this as it seems to be symptomatic of my personality and the journey that has led me towards becoming a counselling psychologist. Moreover, I would argue that counselling psychology itself embraces these contradictions, its roots being firmly based within a humanist tradition, and yet embracing the teaching of CBT and psychodynamic therapy within its training programmes.

My interest in EDs stems from the experience of my eldest daughter, to whom this thesis is dedicated. She died from drowning on 23 February 2015, aged 22, following a hyper-manic episode. She had largely overcome her BN, and was supportive of me writing this thesis, but had other mental-health problems which probably constituted undiagnosed bipolar disorder. I had just begun the process of data collection when her death occurred and, after pausing for several months, elected to finish this research rather than begin afresh. There is no doubt that I was motivated by a need to understand

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EDs for my daughter's sake and for my own. This need has been immeasurably strengthened by her death, as has my desire to work with ED patients in my professional practice.

Gender forms a key part of this study, with most of the male participants having worked with female therapists, as well as struggling to come to terms with what they perceive to be a female condition. A brief look at some ED-service websites suggests that, at the time of writing, it is possible that more than 90% of frontline staff working in the trusts represented are female. The chances of men receiving treatment from someone of the same gender are very slim. Equally, the chances of a male therapist finding a male client in such a service are similarly small. I had the good fortune to find a placement within a highly-respected community eating disorder service. I was the only male member of staff and, at the time of my placement, only 5% of clients were male. Although I undertook a brief intervention with an autistic man, there were no male patients available for me to work with in a sustained manner. It is for this reason that my case study is based upon a woman with AN.

A key aspect of my ED work was the persuasiveness of the trans-diagnostic model, something that was strengthened by the experiences of the participants in my research, many of whom had also had episodes of AN and binge-eating disorder (BED). Choosing a woman with AN for my case study provides an interesting contrast to the concerns expressed in the research, as well as providing an alternative gender perspective. It was also interesting to me because it mirrored the experience of most men who are usually required to meet with a therapist of the opposite sex. It should be noted, however, that "Alice" had the choice of having a same-sex therapist, something rarely available to men.

Prior to becoming a psychologist, I studied archaeology and spent much of my life working on the development of information standards for museums and the historic environment sector. I loved creating, but would have hated implementing them. In much the same way, I admire the rigour and evidence base of CBT, but also love the relatively

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unconstrained nature of person-centred therapy (PCT). When implementing CBT, I am happy to follow protocols, adapting them in a way that can be justified for the needs of individual clients. But I can also be moved to follow my instinct when I believe that it will be of benefit. In practice, the two models may seem very different, but they can complement each other well. To use an analogy, I enjoy cooking and will follow tried-and-tested recipes, as well as creating meals based on what is in my cupboard or fridge. Exciting new things can be achieved through exploration, creativity and imagination, but it is sometimes necessary to follow best practice. I would never let an egg decide how long it wants to be boiled.

Casemore and Tudway, in making a case that CBT and PCT are “siblings, not rivals” state:

The most important and singularly most different aspect of the person-centred approach is the belief that this is a way of life, a way of being that is itself therapeutic and not a set of tools to be ‘switched on’ in therapy. (Casemore & Tudway, 2012)

When CBT tools are only being used in this way, it cannot be said that change has really occurred. CBT involves challenging the ways in which we perceive and think about situations, resulting in changed ways of feeling and behaving. If we practice these and integrate them into our everyday lives, they eventually become second-nature. There is a difference between practicing mindfulness and living mindfully.

Perhaps key to the dilemma is what appears to be the fundamental differences between the two models in what it is that achieves change. Central to the person-centred model is Roger’s belief that change is a continual process. Rather than changing from one state of “fixity” to another, Rogers identified a,

“...significant continuum....from fixity to changingness, from rigid structure to flow, from stasis to process.” (Rogers, 1967, p. 131).

In practice, such change takes place at different paces, and can include “seismic change” and “osmotic change” (Mearns & Thorne, 2007, p. 193). Rather than being achieved through learning, the person-centred model assumes that change occurs through the removal of impediments to self-actualising. Rogers himself gave a somewhat nihilistic

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account of the utility of teaching (Rogers, 1967), and yet he continued to lecture and wrote prolifically. It seems to me that he is correct when he wrote, *“I have come to feel that the only learning which significantly influences behaviour is self-discovered, self-appropriated learning.”* (Rogers, 1967, p.276), but this does not mean that teaching does not have a role to play. The importance is in the words “self-appropriated”. Instructors are required when learning how to drive, but an individual has to want to drive, and it is through practice that the learning is assimilated. It is for this reason that collaboration is such an important technique in CBT, with the use of jointly-designed behavioural experiments to facilitate self-discovery and cement learning. There should be no inconsistency in a client choosing to have CBT or undertake self-exploration through psychodynamic therapy as part of their self-actualising journey.

Section A: Doctoral thesis

This section consists of the doctoral thesis entitled, *“Male lived experience of binge eating and compensatory behaviours”*. Conducted using interpretative phenomenological analysis (IPA), this study is focussed on the experience of the onset, development and (where present) recovery from BN. Eight semi-structured interviews were conducted from a sample of men self-reporting as having at some time in their lives met the diagnostic criteria for BN. The interviews were transcribed and analysed using the methodology prescribed for IPA (Smith, Flowers, & Larkin, 2009). The results are presented in the context of relevant literature and theory, before concluding with a discussion of the implications of the findings for counselling psychology, along with recommendations for further research.

Section B: Client case study

The case study consists of a piece of clinical work centred around a young female client referred to an NHS community ED service with a diagnosis of AN. It follows my use of Cognitive Behavioural Therapy for Eating Disorders (CBT-E), focussing on the

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work conducted over a total of ten sessions, from engagement to review. It describes the context of the ED service, the client and her presenting problem, the formulation of this problem, and the implementation of the first phase of treatment aimed primarily at soliciting a commitment to change.

I selected this client for several reasons. On a practical level, I was able to reflect on a completed phase of the treatment protocol. Secondly, as a male therapist working with a female client, the study provides an interesting insight into the gender issues arising in this client group, and the challenges of developing a strong therapeutic alliance when most of my clients are likely to be female. Thirdly, it allowed me to explore the full range of modalities presented in counselling psychology training, and consider how these impact on professional practice: My naturally person-centred approach had to be curbed or adapted to suit the implementation of a cognitive-behavioural model, whilst being challenged by a supervisor working primarily within a psychodynamic frame of reference. It shows how the development of a strong therapeutic alliance was transformational within the therapeutic process, and how I benefitted from a more questioning approach at the behest of my supervisor. Most of all, I hope that it demonstrates competence in my practice and ability to use CBT-E within an NHS setting, as well as to build alliances that overcome gender barriers.

Section C: Publishable paper

The publishable paper, entitled, "*Experiences of power and control for men with binge eating and compensatory behaviours*", represents a discussion of one of the superordinate themes of my thesis. It outlines the four main themes identified, along with their accompanying subthemes, before focussing on the theme entitled "The need for, and loss of, power and control. The aim is to submit this for publication in the peer-reviewed journal *Counselling Psychology Review*, and it has been structured and formatted in keeping with that publication's guidelines.

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This journal was chosen for several reasons: Firstly, among the findings of this study is a need for better engagement of men with EDs at all stages within the NHS stepped-care model. There is a role for a person-centred approach at an early stage in this process, something that counselling psychologists are uniquely placed to be able to offer. Secondly, there is a need to raise awareness among counselling psychologists that EDs are becoming as much a male as a female problem, and there is a need for more male therapists to work in this area, to provide treatment parity and encourage men to engage in treatment. I hope that by disseminating these findings, greater awareness will be raised of the need for improved provision for men within ED services, as well as the need for further research leading to the development of treatment protocols founded on a firm understanding of how EDs develop in the male population, rather than upon adaptations to models based primarily upon findings related to women.

Summary

This portfolio presents gendered perspectives of EDs within a piece of empirical research of men with EDs, and a case study of a woman with AN. It aims to present to the reader male perspectives on living with an ED, as well as the perspective of a male therapist working with a female client on what continues to be regarded as a female problem. I hope it will also raise questions about the arbitrary nature of diagnostic cut-offs, questioning the way we use diagnoses such as AN and BN when presented with a problem that is arguably transdiagnostic. I also hope that it shows that it is possible to work effectively within more than one therapeutic model, and that integration can result in enhancement rather than dilution.

Section A:

Doctoral Research

Male lived experience of binge eating and compensatory behaviours

Matthew Stiff

Supervised by Dr Courtney Raspin

Chapter 1:

Introduction and literature review

1.1 Introduction

Eating disorders (EDs) have long been associated with industrialised societies, and were thought to be comparatively rare outside Western Europe and North America (Dolan, 1991; Bemporad, 1997). While it remains true that EDs are rarely seen in non-industrialised countries, there is evidence of growth in numbers of instances in Asia and the Pacific as this region experiences rapid industrial expansion and exposure to Western values and culture (Thomas, Lee, & Becker, 2016). Interestingly, similar studies conducted in Latin America, while indicating lower prevalence of anorexia nervosa (AN), have demonstrated a higher point prevalence of bulimia nervosa (BN):

A possible explanation might be that food has a high emotional value in many Latin American cultures which reflects in the language (e.g., ‘Las penas con pan duelen menos’, – the sorrows with bread hurt less, ‘barriga llena, corazón contento’ – a full belly is a pleased heart).... (Kolar, Rodriguez, Chams, & Hoek, 2016)

This reveals the complexity of our relationship with food, with societal and cultural changes competing with long-established emotional influences.

Just as EDs are increasingly being recognised in parts of the World previously thought to have been immune from them, so we are seeing changes in the prevalence of EDs across gender in a process that has been described as “the ‘democratisation’ of disordered eating” (Mitchison, Hay, Slewa-Younan, & Mond). Despite this, the recognition and treatment of men with EDs lags far behind that of women (Strother, Lemberg, Stanford, & Turberville, 2012), with EDs in men continuing to be under recognized (Greenberg & Schoen, 2008). This may, in part, be due to a general reluctance of men to seek medical help (Yousaf, Grunfeld, & Hunter, 2015), but also due to men failing to recognise symptoms in themselves of disordered eating because they

have absorbed the myth that EDs are primarily female conditions (MacLean, et al., 2015). Until men receive parity with women, both in terms of treatment and research focus, it is likely that they will continue to avoid seeking help from a system that is not geared towards their needs.

This invisibility is particularly pronounced when it comes to BN since it is usually less obvious that individuals with this disorder are suffering from an ED. BN is associated with strong feelings of shame caused not only by the episodes of bingeing, but also by the nature of some of the associated compensatory behaviours (Olatunji, Cox, & Kim, 2015). When men do recognise symptoms of EDs in themselves, there is likely to be additional shame associated with having what many perceive to be a feminine problem (Poole, 2014).

This thesis seeks to play a part in redressing this imbalance by contributing to the body of literature looking at male experiences of BN. Because most participants in this study have never received a formal diagnosis, the focus is on “male lived experience of binge eating and compensatory behaviours” (BECB): men who fulfil the diagnostic criteria for BN based on self-report. This chapter begins by looking at definitions of key concepts associated with EDs, and BN in particular. It then goes on to look at prevalence, comorbidity, mortality and aetiology, before discussing qualitative research and individual accounts of BN and Binge-Eating Disorder (BED). It concludes by summarising the research rationale for this study and its potential contribution to counselling psychology.

1.2 Definitions and key concepts

A wide range of terminology is used in the discussion of EDs, and it is helpful to have an overview of some of the key concepts involved. These are explored in the following sections.

1.2.1 Sex, gender, gender identity and sexuality

“Sex” and “gender” are often used synonymously, and the same is true for “gender” and “gender identity”. This is further confused by the use of terms such as “masculinity” and “femininity”, with Constantinople (1973) arguing that these are amongst the muddiest used in psychology (and this without including “androgeneity”). That these concepts are in a state of flux is evident from the changes that have taken place in the last thirty years. In 1985 Deaux defined sex as, “the biologically-based categories of male and female”, and gender as, “the psychological features frequently associated with these biological states” (Deaux, 1985, p. 51). Whilst acknowledging the concept of gender identity, Deaux leaves this for others to discuss. The concept of “gender” is much more ambiguous than it once was, having for many years been seen in binary terms, and often used synonymously with “sex” (Pryzgodna & Chrisler, 2000). Pryzgodna and Chrisler’s work demonstrates the breadth of interpretation applied to the terms “gender” and “sex”, and where their definitions diverge it is frequently because “gender” is being used synonymously with “gender identity”.

Fagot and Leinbach (1989) have shown that by the age of three, children have a sense of their gender identity, but this appears to be expressed in terms of relatively superficial differences, such as the way they look, dress or behave, and has no sense of permanency. The idea of gender constancy was once thought to be related to Piaget’s concrete operational stage of cognitive development (Kohlberg, 1966), but it is now thought to be more knowledge-based (Bem, 1989). There is greater uncertainty about the development of gender identity beyond early childhood. Citing Philips (2006), Thornton has written,

Changes in women’s self-concepts and behaviour have created a ‘crisis’ in masculinity, forcing men to reconsider what it means to be male and spawning the new field of ‘men’s studies’. (Thornton, 2008)

The use of the word ‘crisis’ seems unduly negative since comparable changes for women and society have more generally been referred to as ‘liberation’ (De Beauvoir, 2011).

Nevertheless, it is true that the women's movement has seen a challenging of the terminology used to define gender which has had repercussions for men too.

This thesis adopts the following definitions in accordance with APA best-practice in use of terminology (APA, 2015):

- 1. Sex:** This refers to “a person's biological status and is typically categorized as male, female, or intersex (i.e., atypical combinations of features that usually distinguish male from female)” (APA, 2015, p. 20). The determination of an individual's sex can be made on the basis of a combination of sex chromosomes, genitalia, reproductive organs etc.
- 2. Gender:** This refers to “the attitudes, feelings, and behaviors that a given culture associates with a person's biological sex” (APA, 2015, p. 20). This places a social and cultural dimension on gender, along with associated expectations. The key point is that gender is defined by culture/society rather than the individual. The degree to which an individual's behaviour conforms with these expectations is discussed in terms of gender conformity/non-conformity. Conformity can also be referred to as “gender-normative”. (Courtenay, 2000; Buchbinder, 2013).
- 3. Gender Identity:** This refers to

....a person's deeply-felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender non-conforming, boygirl, ladyboy) which may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics (APA, 2015, p. 20).

This means that gender identity is defined by the individual rather than the culture/society they engage with. As it is a psychological construct, an individual's gender identity may not be obvious to observers. It is also not a fixed construct, with individuals identifying differently at various stages in their lives, and sometimes assigning different gender identities to various aspects of their personality.

4. **Gender expression:** This refers to “an individual’s presentation, including physical appearance, clothing choice and accessories, and behavior that communicates aspects of gender or gender role” (APA, 2015, p. 20). It is important to note that an individual’s gender expression may not necessarily be the same as their gender identity or sexual orientation.
5. **Sexual orientation:** This refers to “the sex of those to whom one is sexually and romantically attracted” (APA, 2015, p. 22). Typically, this includes opposite-sex attraction (heterosexual), same-sex (gay/lesbian), or both sexes (bisexual). Individuals preferring not to categorise their sexuality in binary terms may identify as pansexual. It has been argued that, like sexual identity, sexual orientation is a fluid construct, with some individuals choosing to experiment with their orientation without being bound by categories such as “heterosexual” or “bisexual”.
6. **Transgender:** This is “an umbrella term that incorporates differences in gender identity wherein one’s assigned biological sex doesn’t match their felt identity” (APA, 2015, p. 22). Although individuals may identify as transgender, this does not necessarily mean that they will wish to undertake gender-reassignment surgery or hormonal treatment. Instead, they may choose to adopt a non-binary gender identification.

1.2.2 Eating and feeding disorders

Definitions pose a problem in the study of eating disorders. Like most conditions covered by the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual DSM-5 (APA, 2013) and the World Health Organisation’s (WHO) International Statistical Classification of Diseases and Related Health Problems ICD-10 (WHO, 1992), diagnosis is criteria based. Alterations to these criteria between versions may have a direct bearing on whether an individual is diagnosed as having an eating disorder rather than disordered eating.

Changes from the DSM-IV-TR (APA, 2000) to the DSM-5 resulted in revisions to the diagnostic criteria for both AN and BN, the recognition of BED as a disorder, and the replacement of Eating Disorder Not Otherwise Specified (EDNOS) with Otherwise Specified Feeding and Eating Disorders (OSFED). This has led to many people, previously diagnosed with EDNOS, now meeting the criteria for BED, AN or BN.

DSM-5 defines an ED as follows:

Feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning. (APA, 2013, p. 329)

The DSM-5 categorises seven EDs: Pica, Rumination Disorder (RD), Avoidant/Restrictive Food Intake Disorder, AN, BN, BED and OSFED. The inclusion of OSFED allows for the recognition of patients exhibiting most of the criteria for diagnosis of AN, BN or BED but not falling within a characteristic weight range (AN), or not meeting frequency and/or duration criteria (BN and BED - APA, 2013). OSFED also includes Purging Disorder (PD), described by DSM-5 as, “the repeated regurgitation of food occurring after feeding or eating over a period of at least a month” (APA, 2013, p. 232). Avoidant/Restrictive Food Intake Disorder is a condition that develops in infancy/early childhood and is beyond the scope of this thesis.

1.2.2.1 Pica and Rumination Disorder

Pica and RD are peripheral to this thesis, although one participant continues to be affected by RD. A brief summary is provided here to facilitate distinction from AN, BN and BED. Pica is summarised in DSM-5 as, “Persistent eating of non-nutritive, non-food substances over a period of at least a month”. The examples given include paper, hair, cloth, string, charcoal etc. (APA, 2013, pp. 329-330). RD is described as, “repeated regurgitation of food over a period of at least 1 month”. Once regurgitated, the food may be rechewed, re-swallowed or spat out (APA, 2013, p. 332).

1.2.2.2 Anorexia Nervosa (AN)

Although the term “anorexia nervosa” was first coined in 1874 by Sir William Gull (Gull, 1874), the first medical description is usually attributed to Richard Morton in 1689, and there are numerous examples of “holy anorexics”, with figures such as Saint Catharine of Siena using fasting as a form of bodily and spiritual control in searching for God (Pearce, 2004). APA identifies three key features which characterise AN:

....persistent energy intake restriction; intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain; and a disturbance in self-perceived weight or shape. (APA, 2013, p. 339)

Of particular relevance to this thesis is the so-called “binge eating/purge type” (see Section 1.2.2.5).

1.2.2.3 Binge eating Disorder (BED)

Among the earliest clinical descriptions of binge eating is Albert Stunkard’s 1959 study on eating patterns and obesity. Describing an eating binge, he writes:

....such eating often has an orgiastic quality, and enormous amounts of food may be consumed in relatively short periods. (Stunkard, 1959)

Binge eating did not appear in the DSM until the third edition in 1980, and then only as a diagnostic feature of BN. DSM-III describes binge eating as, “....rapid consumption of a large amount of food in a discrete period of time, usually less than two hours” (APA, 1980, p. 70), a definition much in keeping with that of Stunkard. It was formally included as a category in its own right in the DSM-5 (APA, 2013). The DSM-5 defines binge eating as:

1. *Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.*
2. *A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating). (APA, 2013, p. 350)*

This definition of binge eating is identical to that used in the DSM-5 BN criteria, and like BN is expected to occur “on average, at least once per week for 3 months” (APA, 2013, p. 351). Additional criteria for BED, not used for BN, include rapidity of eating, fullness,

quantity of food consumed when not hungry, solitary eating, feelings of self-disgust, depression or guilt.

1.2.2.4 Bulimia Nervosa (BN)

The term “Bulimia nervosa” first appears to have been used by Russell (1979), although the eating of large quantities of food followed by purging behaviours has been recorded since antiquity. These cannot necessarily be equated with BN as we currently understand it, however, as the motivation for purging often appears to have been one of self-cleansing or for curative purposes (Nasser, 1993). Crichton (1996) has suggested that the emperors Claudius and Vitellius may have suffered from a form of BN, but Russell (1997) emphasises that such behaviours were relatively common amongst the elite in the early Roman empire. Among the earliest clinical descriptions of symptoms analogous to the current DSM-5 diagnostic criteria are those of “Nadia”, observed by Pierre Janet (Pope, Hudson, & Mialet, 1985).

The DSM-5 describes BN in the following manner:

There are three essential features of bulimia nervosa: recurrent episodes of binge eating (Criterion A), recurrent inappropriate compensatory behaviors to prevent weight gain (Criterion B), and self-evaluation that is unduly influenced by body shape and weight (Criterion D). (APA, 2013, p. 345)

It further stipulates in a fifth criterion that these features should “not occur exclusively during episodes of anorexia nervosa. This thesis uses the DSM-5 diagnostic criteria for Bulimia Nervosa (BN) as the basis for selecting participants for inclusion in the study, although this is based on self-report as many had not received a formal diagnosis.

1.2.2.5 Diagnostic crossover and the trans-diagnostic perspective

During the development of the DSM-5, considerable emphasis was placed on the need for revisions to the classification of EDs to reduce over-reliance on the EDNOS category. This approach seems to have been aimed at focussing on factors that would allow clearer differentiation between the conditions experienced by ED patients rather than what they have in common (Grave, 2010). Nevertheless, this very process of re-

division and classification demonstrates the often-arbitrary nature of the cut-off between one ED classification and another. Many individuals previously classified as suffering from EDNOS are now diagnosed as having BN simply because of a relaxation of the frequency criteria for purging episodes (Attia, et al., 2013). Fairburn et al. (2008) have noted that up to 90% of patients with AN develop binge eating, and up to 50% full-blown BN. This tendency towards “diagnostic crossover” led to the questioning of the diagnostic schema for BN and AN during the development of the DSM-5 (Eddy, et al., 2008), but this type has remained a feature of the AN classification (APA, 2013).

The basis for the transdiagnostic theory for EDs is neatly summarised by Loeb et al. (2012). Firstly, they draw attention to the blurring of boundaries, with key diagnostic features such as binge eating occurring in AN, BN and EDNOS. Secondly, they cite a core pathology proposed by Fairburn and his colleagues (Fairburn, Cooper, & Shafran, 2003; Fairburn, 2008) that addresses the mechanisms maintaining symptoms across the different ED classifications. Thirdly, they argue that a transdiagnostic theory is more adaptable to prodromal cases, particularly to be found in adolescence, where individuals demonstrate symptoms of marked severity but do not fit into the restrictive definitions of particular EDs. It should be noted that some of the arguments of Loeb et al. were addressed in the reordering and reclassification of EDs in DSM-5, but the basic thesis of the transdiagnostic model continues to present a compelling argument. Further support for this approach comes from the work of Hilbert et al. (2014) looking at risk factors across EDs. Many of these are shared between AN and BN, and between BN and BED, although less so between AN and BED. They note the tendency towards migration from one condition to another and see BN as bridging the gap between AN and BED.

1.2.3 Inappropriate Compensatory behaviours

Inappropriate compensatory behaviours are particular features of BN, although they can also manifest themselves in other EDs, including the binge/purge subtype of AN (APA, 2013). Patients with EDs usually use a combination of compensatory

behaviours, the most common being fasting, vomiting, diuretics, laxative use and excessive exercise. Enema's are sometimes used, but rarely in isolation (Coovert & Powers, 1988).

There is evidence to suggest that the use of multiple purging methods is linked to increased severity of the ED (Haedt, Edler, Heatherton, & Keel, 2006; Edler, Haedt, & Keel, 2007). In earlier editions of the DSM, compensatory behaviour forms the basis of two sub-types of BN: purging and non-purging: the latter used to describe BN where the compensatory behaviour is limited to fasting or excessive exercise (APA, 2000). This was dropped for the DSM-5, the distinction being seen as not particularly helpful given the common use of more than one compensatory method, often drawn from both subtypes. The following sections summarise the main compensatory methods employed in BN.

1.2.3.1 Self-Induced Vomiting

DSM-5 describes self-induced vomiting as the most commonly used form of inappropriate compensatory behaviour (APA, 2013), although this is contradicted by other studies which indicate that “non-purging” methods, including excessive exercise and fasting are more prevalent (Abebe, Lien, Torgersen, & von Soest, 2012). The DSM-5 also reports that for some individuals:

....vomiting becomes a goal in itself, and the individual will binge eat in order to vomit.... (APA, 2013, p. 346)

Most individuals report using their fingers or foreign objects, such as toothbrushes, to induce the gag reflex, although some studies have shown that up to 15% are able to vomit spontaneously (Fairburn & Cooper, 1982). Use of an inserted hose to induce vomiting has been reported for Japanese women with AN, but there appear to be no studies of this for BN (Horie, et al., 2016). Often patients use an emetic, such as drinking salt water, to initiate the purge (Matsha, et al., 2006). Other emetics include over-the-counter medications, such as ipecac (Mehler, 2003). Sometimes individuals report drinking large volumes of water before and during bingeing to facilitate vomiting and as

a “washout technique” to ensure removal of all food traces. Vomiting is occasionally interspersed with eating, but most often it takes place following a binge (Abraham & Beumont, 1982).

There are numerous side-effects associated with vomiting as a purging method. One of the most common (and most revealing to external observers) is erosion of dental enamel. This is usually to be found on the palatal surfaces of teeth, making it more likely to be discovered during a dental inspection (Uhlen, Tveit, Stenhagen, & Mulic, 2014). More life-threatening abnormalities include electrolytic imbalances, the most frequent problem being hypokalemia (low potassium levels). This can lead to cardiac arrhythmias and renal abnormalities, in extreme cases resulting in renal failure requiring dialysis. (Pomeroy & Mitchell, 2002). There is also evidence that self-induced vomiting can cause an increased risk of oesophageal cancer (Matsha, et al., 2006).

1.2.3.2 Laxatives

Laxatives are substances that result in increased bowel movement through the loosening of stools caused by increased faecal water excretion (Binder, 1977). Research suggests that laxative abuse is one of the least common compensatory behaviours for EDs in general, with a study of a cohort drawn from ED sufferers showing it used by 6.2% of men and 10.8% of women. This study also demonstrated a higher female lifetime prevalence in the use of laxatives for weight control, with 38.5% of women within the cohort having used them at some point as opposed to 12.3% of the men (Button, Aldridge, & Palmer, 2008). Nevertheless, it has been cited as the second-most-common purging method used by individuals with BN (Mehler & Rylander, 2015).

Laxatives are an inefficient way of limiting calorific intake, with one study suggesting that their use results in a reduction in calorie retention of only approximately 12% (Bo-Linn, Santa Ana, Morawski, & Fordtran, 1983). Effects of prolonged laxative abuse include melanosis coli (a discolouration of the colonic mucosa) and cathartic colon syndrome, a more serious condition resulting in potentially-permanent changes to the

anatomy and physiology of the colon. This can result in abdominal pain, abdominal bloating, constipation, and/or an inability to fully evacuate the bowel. Severe instances may require an ostomy (Mehler & Rylander, 2015). In rare instances, laxative use can also result in pancreatitis or encephalitis (Mickley, 1999).

1.2.3.3 Diuretics

Diuretics are substances that cause increased excretion of water from the body resulting from increased urine production in the kidneys. Although diuretic use results in temporary weight loss, this is attributable to dehydration and is reversed when rehydration occurs. The calorific value of healthy urine is minimal as the role of the kidneys is to excrete excess water and electrolytes rather than food energy (Hall, 2015). Diuretic abuse can result in renal complications, as well as electrolytic disturbances, such as hypokalemia. It can also lead to dermatological problems, including dry skin, brittle nails and hair loss (Fairburn & Brownell, 2002). Hypovolemia (a reduction in the volume of blood circulating in the body) can also occur, particularly as a result of diuretic and laxative abuse (Pomeroy & Mitchell, 2002).

1.2.3.4 Fasting

The DSM-5 sees fasting as a non-purging compensatory behaviour involving not eating or severely restricting food intake (APA, 2013, p. 346). In the “dual pathway” model of BN, dietary restriction is seen as a response to societal pressure for thinness, precipitating the BN rather than being seen more specifically as a compensatory behaviour (Stice, Nemeroff, & Shaw, 1996; Stice & Agras, 1998). As we have seen, Fairburn has shown that BED and/or BN are almost inevitable consequences of the dietary restriction seen in AN (see Section 1.2.2.5). Nevertheless, fasting is observed in patients who have not previously shown symptoms of AN or a focus on a thin ideal. It differs from AN in that it usually occurs in response to a bingeing episode, rather than as a general feature of the ED itself.

The reasons for fasting or restriction are varied, and sometimes appear to go beyond the desire simply to compensate for the calorie intake of a bingeing episode. In some instances, it is used as a means of relieving the discomfort of a distended stomach resulting from over-eating, although there is evidence to suggest that repeated episodes of bingeing result in increased gastric capacity, thereby alleviating this effect (Geliebter, et al., 1992). In others, it appears to be used as a form of self-punishment (Treasure, 2007).

1.2.3.5 Excessive exercise

DSM-5 refers to “excessive exercise” as one of the characteristic methods of purging employed by patients with BN. As used originally in the DSM, “excessive” appeared to refer to the duration of the exercise (APA, 2000). Adkins and Keel (2005) argue that it is the compulsive quality of the exercise that is more significant, and the DSM-5 clarifies this by defining exercise as excessive:

“...when it significantly interferes with important activities, when it occurs at inconvenient times or in inappropriate settings, or when the individual continues to exercise despite injury or other medical complications.”
(APA, 2013).

As with fasting, a primary goal of exercise is to compensate for the calorie intake of binges, but in some instances, it also appears to be employed as a form of self-punishment.

1.3 Literature review

1.3.1 ED Prevalence

ED prevalence is calculated by counting the incidence within a given population, but this can be based upon point prevalence (the number of individuals in a population having the condition at a particular point in time), cumulative incidence (the number who have become ill by a certain point in time) or lifetime prevalence (the number becoming ill within their full lifespan) (Keski-Rahkonen & Mustelin, 2016). These variations in approach add to the difficulties in drawing comparisons between studies.

Obtaining information on the prevalence of EDs within a general population is problematic because of the tendency among many sufferers either to fail to recognise that they have a problem, or to be reluctant to admit it to others (Konstantakopoulos, Tchanturia, & David, 2011). Community studies are expensive to conduct, meaning that most data used in studies is derived from medical records. Micali et al. (2013) show a general increase of around 15% in EDs from 2000 to 2009, with the greatest growth shown among men, rising by 27%. However, this study is based on records from general practice rather than the community at large, meaning that the data is more representative of those who seek help, and where the severity of the condition has been assessed by a health professional. This is further complicated by the recent changes in diagnostic criteria for DSM-5 meaning that many previous longitudinal studies will have been based upon DSM-IV-TR (or earlier) criteria.

The impact of these changes has been explored in a number of studies, most of which have involved reclassifying DSM-IV diagnoses using DSM-5 criteria, but this is only possible where access to the original data is available. Fairburn and Cooper (2011) used the DSM-5 proposals in their reappraisal of 167 adult patients diagnosed with EDs using the Eating Disorder Examination interview (Fairburn, Cooper, & O'Connor, 2008), resulting in AN diagnoses increasing from 8.4% to 28.7%, EDNOS falling from 52.7% to 25.1% (OSFED/UFED were not used in this study), 7.2% being classified as BED, and BN remaining unchanged on 38.9%.

Recent research has provided conflicting evidence on the prevalence of EDs. Keel et al. (2005) have shown a decrease in point prevalence for BN which they argue is not explained by changes in service utilization. However, Micali et al. (2013) have shown that from 2000-2009 rates rose, with incidences of BN and AN remaining static but EDNOS accounting for the majority of this increase. Recent changes to the classification of EDs in DSM 5 mean that some former incidences of EDNOS will now fall within the diagnostic criteria of BN and AN (Pearson, 2013). Hoek (1991; 2007) has shown that the incidence of BN is 50% higher than AN and that the risk is three times

higher for those living in cities (Van Son, Van Hoeken, Bartelds, Van Furth, & Hoek, 2006). Studies indicate the percentage lifetime prevalence for BN among adolescent males to range from 0.5 percent (Hudson, Hiripi, Pope, & Kessler, 2007) to 1.4 percent (Patton, Coffey, Carlin, Sanci, & Sawyer, 2008).

Methodological differences make it difficult to draw firm conclusions from studies into the prevalence of BN within population groups and sub-groups. Some estimates are made on the basis of clinical diagnosis, whereas others are based upon self-report of bulimic symptoms from samples taken from the general population. An additional problem is the effect of societal and cultural pressures on willingness to seek help or to report bulimic behaviours honestly.

Initial studies have suggested that BN is primarily a condition of developed Western countries, mainly affecting white women. A recent review of the literature, however, suggests the incidence of BN is increasing in non-Western countries. Makino, Tsuboi, and Dennerstein report that population and clinic-based estimates of BN in Western countries range from 0.3% to 7.3% in female subjects and 0% to 2.1% in males. This compares with equivalent studies suggesting rates of 0.6% to 3.2% in non-Western countries (insufficient data exists to sub-divide these figures according to gender). Although these figures are lower than in Western countries, the gap appears to be closing. They attribute this to economic change and growing social pressure “resulting from the standards of female beauty imposed by modern industrial society or Western culture” (Makino, Tsuboi, & Dennerstein, 2004).

BN is significantly more common among women than men, but the ratio is probably smaller than the 10:1 previously thought. The recent US National Comorbidity Survey Replication (Hudson, Hiripi, Pope, & Kessler, 2007) found rates among women and men to be 1.5% and 0.5% respectively (a ratio of 3:1). It has also been suggested that men typically under-report bulimia and other eating disorders, possibly because they are associated with women. In a recent study of 93 male college students in Australia, 9% reported eating disorders including BN and BED but none had sought help from

healthcare professionals (O'Dea & Abraham, 2002). Meyer et al. (2005) also report an apparent difference in state anger between men and women, with men engaging in bulimic behaviour as a means of reducing anger states and women more likely to do so to prevent those states arising in the first place.

Gay men also appear to be a particular risk group (Russell & Keel, 2002), possibly due to greater body dissatisfaction compared with heterosexuals. Heterosexuals expressing body dysmorphia tend to want to be heavier, in contrast to homosexuals who more often express a desire to be lighter and thinner (Silberstein, Mishkind, Striegel-Moore, Timko, & Rodin, 1989; Yelland & Tiggemann, 2003). These findings are reinforced by the work of Feldman and Meyer (2007) who in a study of 126 white heterosexuals and 388 gay, lesbian and bisexual men and women of white, black and Latino ethnicity found that gay and bisexual men were more than ten times as likely to develop bulimia as heterosexual men. They also observed that the within-group risk increased significantly for gay and bisexual men who participated in gay social and recreational groups. The study showed that there were no significant differences between bisexual and heterosexual women and lesbians.

1.3.2 Comorbidity

DSM-5 lists a number of psychiatric conditions associated with BN, including mood disorders such as Dysthymic Disorder and Major Depressive Disorder. It suggests that in most instances, onset of these conditions usually occurs at the same time or after that of BN. It also notes the lifetime prevalence of substance dependence or abuse among approximately 30% of participants experiencing or recovering from BN (APA, 2013).

In a study of lifetime psychiatric disorders among 1498 women drawn from a general population, and 30 clinical patients from the Christchurch area of New Zealand, Bushnell et al. (1994) report lifetime levels of substance abuse at 24% in the general population and 44% in the clinical population. They also noted lifetime prevalence for

affective disorder of 34% and 84% respectively. Mood is directly related to the bingeing/purging cycle. Alpers and Tuschen-Caffier (2002) have shown that compared with control groups, BN participants show peak negative feelings in the hour prior to bingeing, returning to normal after purging. A number of studies have hypothesized that BN may represent a form of obsessive compulsive behaviour (OCD). Rubenstein et.al. (1995) found elevated levels of obsessionality among BN participants as compared with a control population. Other studies, however, have found similar evidence for AN but not BN.

There is evidence for comorbidity of BN with Type 1 diabetes. A recent meta-analysis suggests that Type-1 patients are three times more likely to suffer from BN than non-diabetics (Herpetz & Nielsen, 2003). Obesity is also frequently identified as a risk factor for development of BN. Hebebrand, et al. (2002) found evidence of genetic predisposition to obesity in a study of 81 female BN patients, although it should be noted that this is based upon one individual in the sample (the authors state that the study and control groups would need to be in excess of 615 for the linkage to be statistically proven). With diabetes, it is possible that BN is being used as a means of regulating weight without proper consideration of its negative impact.

1.3.3 Mortality

Prioritisation for treatment and research funding has tended to favour AN rather than BN, BED or OSFED, possibly because of a perception of the higher mortality risk posed. US figures give combined spending for research on all EDs, and only provide individual data for AN – (National Institute of Health, 2013). Recent meta-studies show conflicting data on comparative mortality rates, with one suggesting a standardized mortality ratio (SMR) of 1.57 for bulimia and 1.70 for AN. Given that the prevalence of BN is significantly higher than that for AN, for a given population the overall numbers of deaths linked to BN are greater than those for AN. This is attributable to a much higher

risk of suicide for individuals with BN, thereby warranting greater attention from practitioners, researchers and policy-makers (Crow, et al., 2009).

1.3.4 ED Aetiologies

Numerous theories exist for the cause and development of EDs in individuals. The following sections explore emotional and biological models for ED aetiology, with special reference to BN and BED.

1.3.4.1 Emotional models

Emotional models look at psychological theories underlying the development of EDs. They focus on emotional factors rather than biological or societal explanations for ED development. A number of emotional models and theories are explored here, including Attachment Theory, Affect Regulation Theory, Escape Theory and Restraint Theory.

1.3.4.1.1 Attachment theory

Attachment theory owes its origins to John Bowlby and Mary Ainsworth (Bretherton, 1992). Bowlby's premise was that:

....the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment.... (Bowlby, 1952)

Bowlby stressed the importance of a strong emotional bond with at least one caregiver (not necessarily a birth parent), enduring across time. Where primary care is inconsistent or neglected altogether, insecure attachment can develop with potentially long-term risks to a child's ability to form secure relationships and develop strong self-esteem.

Insecure attachment can also impact on the ability of patients with EDs to form strong relationships with therapists, although it has also been argued that when such strong alliances do occur, they can form a basis for enabling patients to experience strong and healthy relationships beyond the therapy room. There is evidence that AN patients feel a burden of responsibility to promote familial harmony, but this appears to

be less strong for BN (Chassler, 1997). A more recent meta-analysis supports the link between insecure attachment and EDs but states that the mechanisms for this remain unclear (Zachrisson & Skårderud, 2010).

There is a growing body of literature examining perceived parenting styles and their relationship with EDs. In a study of 70 ED patients, Jauregui Lobera, Bolanos Rios and Garrido Casals (2011) found that between 8.6% and 12.9% of participants saw their parents as neglectful, with a perception of low care and high control. They also found that those patients who perceived their fathers as being neglectful during their childhood showed higher scores for bulimia when compared with patients reporting other styles of paternal parenting.

In a study of women with BN conducted in a non-clinical setting, Kent and Clopton (1992) found that participants did not report higher family conflict and lower caring than the control, although this contrasts with other studies conducted in clinical settings (Jauregui Lobera, Bolanos Rios, & Garrido Casals, 2011). This may be because the comparative reluctance of men to seek help means that those who do find themselves in treatment settings represent a subgroup, possibly having experienced greater exposure to specific risk factors.

In a study of risk factors for BED among black and white women, Striegel-Moore et al. (2005) found no significant effects for ethnicity, but BED women did report greater childhood obesity and exposure to family over-eating (see Section 1.3.4.3.4) and discord (see Section 1.3.4.3.5). In particular, the BED group reported parents being more demanding than the healthy control group or those with other psychiatric disorders.

There is also evidence that gender role behaviour (see Section 1.3.4.3.3) is encouraged through parenting styles. Parents have long been seen to play an active role in children's play style, with Tauber (1979) observing that parents of girls tended towards participating in sociable play whereas those of boys veered towards active play. Scholars have continued to observe these sex differences, with Berenbaum et al. (2008) noting that in comparison with girls, boys' play tends to be

....more characterized as active, dominance-oriented, and physically-assertive. (Berenbaum, Lynn Martin, Hanish, Briggs, & Fabes, 2008, p. 278)

They confirm the importance of parental socialising in the context of gendered play, although they emphasise that this process is bidirectional, with children contributing to their own socialisation of play, in turn influencing their parents.

This focus on physical play for boys seems to be linked to a greater emphasis on self-soothing and minimisation of emotional response. In a study of 6 to 8-year-old children and their mothers, Topham et al. (2011) found that emotional eating was positively predicted by the mother minimising response to their child's negative emotion, effectively feeding the idea that "big boys don't cry". This is a notion that is encouraged through parenting, but then becomes a societal gender norm with significant implications for coping behaviours, development of EDs and subsequent help-seeking (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011).

Reciprocity, in particular, has been studied extensively (Bell, 1968; Maccoby & Martin, 1983; Carson & Parke, 1996), with research also suggesting a link between reciprocal connectedness and adolescent emotional functioning (Boutelle, Eisenberg, Gregory, & Neumark-Sztainer, 2009). Studies have shown that lack of parental time and affection are risk factors in ED development (Johnson, Cohen, Kasen, & Brook, 2002). The emotional connectedness between family members is often referred to as "family cohesion" (Ackard, Neumark-Sztainer, Story, & Perry, 2006), and Franko et al. have demonstrated its importance in the development of healthy eating behaviours among adolescent girls (Franko, Thompson, Bauserman, Affenito, & Striegel-Moore, 2008).

1.3.4.1.2 Affect regulation theory

Affect regulation theory focusses on the importance of emotional regulation to individual development and wellbeing. Gross & John consider affect management in terms of antecedent-focussed (occurring before the activation of the emotional response with its associated physical and behavioural characteristics) and response-focussed

(following the triggering of the emotional response and its accompanying behaviours). In particular, they examine different strategies in response to situations, including cognitive reappraisal and suppression (Gross & John, 2003).

Theorists have suggested that ED sufferers use food as a means of emotional regulation for low mood states (Hawkins & Clement, 1984; Macht, 2008). This results in an external focus for hunger and satiety rather than relying on the body's own internal regulatory mechanisms. This need for emotional regulation is closely allied with attachment theory (see Section 1.3.4.1.1).

1.3.4.1.3 Escape theory

The escape theory for binge eating was proposed by Heatherton and Baumeister (1991), and hypothesises that individuals indulging in binge eating have high personal expectations and a strong need for approval from others. A belief in the close critical attention of others combines with strong negative self-assessment to produce negative affect and a desire for escape. This is achieved through episodes of binge eating (Paxton & Diggins, 1997). However, although Paxton and Diggins found a correlation between avoidance coping, binge eating and depression, hierarchical regression analysis showed no significant predictive power for BN over and above that of depression, and therefore urged caution in over-stating the role of escape theory in the aetiology of EDs.

1.3.4.1.4 Restraint theory

Numerous studies have posited a link between dieting and increased risk of BN (Heatherton & Polivy, 1992; Brewerton, Dansky, Kilpatrick, & O'Neil, 2000; Ricciardelli & McCabe, 2001; Shunk & Birch, 2004). More recently, studies have suggested that fasting is an even stronger risk factor for the development of the condition (Stice, Davis, Miller, & Marti, 2008). Herman and Mack's (1975) restraint theory proposes that dieting and fasting leads to decreased sensitivity to bodily cues for satiety, resulting in an over-reliance on contextual information for dietary regulation. This can then lead to the binge/purge cycles common to BN. However, doubt has been cast on this hypothesis by

works that include other independent variables as predictors of BN. Johnson and Wardle (2005) found that body dissatisfaction is more broadly associated with the negative outcomes of BN than dietary restraint.

1.3.4.2 Biological factors

The following sections examine a number of biological factors thought to play a role in ED development. These include the addiction model, and the contribution of genetic, neurocognitive, hormonal and stress regulation factors.

1.3.4.2.1 Genetic predisposition

Studies looking at a genetic aetiology have increased significantly in the last twenty years, and there is a growing body of evidence to support genetic roles in a number of EDs. Monozygotic and dizygotic twin studies, in particular, have helped to further understanding. Kendler et al. (1998) published an important study in which they concluded that there was 22.9% concordance for monozygotic twins and 8.7% for dizygotic twins (compared with an overall prevalence and risk of 2.8% and 4.2% respectively for the sample). From this they concluded that there was a heritable liability of 55%. Using two definitions of bulimia (narrowly-defined and broader, bulimia-like symptoms) their study showed a significantly greater liability for monozygotic twins (0.50) than for dizygotic ones (0.30).

Twin studies are open to criticism because of the difficulty in establishing causality of correlations. Kendler et al. expressed caution in their findings and went on to question what they called the “equal environment” assumption: that both mono- and dizygotic twins have equal environmental exposures during childhood and adolescence (Kendler & Gardner, 1998). In this study Kendler and Gardner found that although the null hypothesis was broadly supported, there was a correlation between co-socialisation and broadly-defined bulimia for dizygotic twins (curiously, not for monozygotic twins).

It has been argued that there is no single BN gene, but a number of genes have been suggested to be significantly involved in the development of the condition. Nacmiasa et

al. (1999) have found evidence for 5-HT_{2A} receptor gene polymorphisms, while Levitan et al. (2001) have found associations between the 5-HT_{1B} receptor gene and minimum lifetime body mass index for BN participants. Rand and Kuldau (1986) have shown a higher prevalence of BN among obese individuals when compared with a non-obese control, and numerous other studies draw attention to obesity in BN patients (Hebebrand, et al., 2002). Genetic studies relating to the aetiology of BN are in their infancy, but it seems likely that candidate genes will continue to emerge, some possibly more general and linked to factors such as obesity, and some more specifically related to eating disorders.

1.3.4.2.2 Addiction model

Comparisons have long been drawn between the behaviour patterns in EDs, such as BN and addictions (Brisman & Siegel, 1984; Gordon, 1990). There is also strong evidence for comorbidity in BN and substance abuse (see Section 1.3.2). Some early critics of the addiction model focussed on the psycho-social aspects of the condition whilst downplaying the physiological evidence (Vandereycken, 1990). Nevertheless, there is a growing body of evidence supporting addiction and reward mechanisms in EDs, and particularly BN.

The DSM-5 lists eleven diagnostic criteria for Alcohol Use Disorder, with the requirement that two or more of these occur at any time within the same twelve-month period (APA, 2013). Many of these have analogues in EDs. Kaye et al. (1988) found possible evidence of tolerance in their study of brain serotonin (5-HT) in female BN patients. Abraham and Beumont (1982) discovered that bingeing is more episodic in patients with recently adopted abnormal eating patterns, while longer-term patients are more likely to report protracted episodes, accompanied by the consumption of higher quantities of food.

If withdrawal is a feature of BN, there is no agreement on the nature of the substance being withdrawn from. However, given the evidence for the selection of

carbohydrate-rich foods during bingeing episodes, it is reasonable to look to related studies involving BED and hypothesised “sugar addiction”. Such evidence exists in rat studies (Wideman, Nadzam, & Murphy, 2005) with a possible linkage to opioid dependence (Colantuoni, et al., 2002). There is also some evidence that BED predicts substance abuse, with Wilson (1993) showing that BED onset appears to precede substance abuse where subjects exhibit comorbidity. Further research is required, however, particularly for BN.

A diagnostic feature of alcohol or opioid use disorder is that the substance is often taken “in larger amounts or over a longer period than was intended” (APA, 2013, pp. 490, 541). Bulimics usually report feelings of disgust in relation to the quantity of food eaten, and a lack of control over duration. Essentially, the bingeing/purging cycle appears to continue until the individual is satiated or disturbed (Kaye, Gwirtsman, Brewerton, George, & Wurtman, 1988).

Lack of control is another common feature of alcohol and opioid use disorders, with individuals demonstrating a “persistent desire or unsuccessful efforts to cut down or control” their opioid or alcohol use (APA, 2013, pp. 490, 541). The feelings of guilt and distress associated with BN provide a strong incentive to seek help. A recent meta-analysis of the findings of 27 studies found full recovery in only 45% of patients, with just under 23% experiencing a prolonged course for the condition (Steinhausen & Weber, 2009).

Another feature of alcohol and opioid use disorders patients is that, “a great deal of time is spent in activities necessary to obtain the [substance], use the [substance] or recover from its effects” (APA, 2013, pp. 491, 541). BN patients frequently report planning binges, although they may also be opportunistic. The secrecy involved in BN means that individuals may go to great lengths surreptitiously to acquire food for a binge. They often report making specific shopping trips to meet the requirements of a binge (which often do not involve the foods that a subject would ordinarily eat):

“I’d go to the store, and I would walk so fast, and my mind wasn’t on anything but to get the food, get out, get home, and eat all the stuff. My mind just raced.... I had to have a successful binge” (Jeppson, Richards, Hardman, & Granley, 2003).

This demonstrates a desire for food that is either driven by compulsion or an addiction-like need.

If BN does bear resemblances to other forms of substance dependence, then we should expect similarities in brain function also to exist. Cocaine and amphetamines, for example, both act as dopamine (DA) agonists, preventing the reuptake of DA (amphetamines also stimulate the terminal buttons to release more DA). The presence of excess quantities of DA in the synapses means that they bind to the post-synaptic receptors for longer, thereby eliciting increased feelings of pleasure and providing positive reinforcement for drug taking. Prolonged use of cocaine or amphetamines results in the reduced ability of dopamine to bind to post-synaptic receptors. This will require greater quantities of the drug to have the same euphoric effect. It also means that when not taking the drug, an individual will be at greater risk of depression because of the reduced effectiveness of the post-synaptic receptors. Negative reinforcement ensures that addicts are less concerned with achieving the high associated with substance abuse than alleviating the negative symptoms associated with not taking the drug (Carlsen, 2010). We have already seen with the comparison with DSM-5 diagnostic criteria for substance dependence that similar behavioural effects can be observed with BN. It might, therefore, be possible to find evidence of similar neurotransmitter activity in the brains of BN patients.

Sugar constitutes a significant part of the food ingested during bingeing episodes. Another possible reward mechanism may, therefore, be derived from endogenous opioids (opioid-peptides synthesised by the body). Endogenous opioids have been linked to drug and alcohol dependence (Reid, 1996). Marrazzi and Luby (1986) hypothesised that both AN and BN represent dependencies based on endogenous opioids. Since then, they have also found evidence for elevated levels of endogenous

codeine and morphine in BN patients when compared with a control. AN participants also showed elevated levels of endogenous codeine but not morphine. Morphine is known to increase food uptake and cause sedation. Marrazzi et al. (1997) have proposed that dieting could in some people trigger an opioid dependency. There has been comparatively little follow-up work on these studies and how their results might fit in relation to other research into the neural activity related to bulimia.

Most addictive drugs, like natural reinforcers such as food and sex, work by triggering the release of dopamine (DA) in the nucleus accumbens. Given this association with food, it would make sense if DA was also implicated in BN. DA and Norepinephrine (NE - also referred to as noradrenaline) are neurotransmitters and hormones. NE is synthesized from DA through the action of dopamine β -hydroxylase. As a neurotransmitter, DA is involved in a wide variety of functions in the brain, but of key importance is its role in the brain's reward system. Elevated DA levels are associated with pleasure and provide positive reinforcement. This can apply to drugs such as cocaine and amphetamines which inhibit DA re-uptake.

NE, when acting as a neurotransmitter, plays a key role in the modulation of heart rhythm. It also acts as a stress hormone and, along with epinephrine, is central to the fight or flight response (Carlsen, 2010). BN patients report relief from feelings of stress and anxiety when engaging in bingeing/purging episodes, so it could also reasonably be expected that disruption of NE neural mechanisms would be found with BN patients. However, the evidence for the involvement of both DA and NE is inconclusive.

Serotonin (5HT) is an indolamine neurotransmitter, synthesised by its precursor, tryptophan (TRP), and its role in appetite arousal and suppression has been of considerable interest to researchers studying BED and BN. This is because of its involvement in appetite, and also because its synthesis can be promoted or inhibited by eating particular combinations of foods. A normal balance of serotonin helps to enhance appetite control and relaxation. Increased serotonergic activity results in suppression of the appetite and increased drowsiness, whereas suppressed levels of serotonin are

associated with disturbed sleep and abnormal eating behaviours (Carlsen, 2010). TRP competes for absorption with large neural amino acids (LNAA) such as isoleucine, leucine, phenylalanine, tyrosine and valine, all of which are to be found in greater abundance than TRP in protein-rich foods (Kaye, Gwirtsman, Brewerton, George, & Wurtman, 1988). Increased levels of carbohydrate, however, promote the release of insulin which elevates the absorption of LNAA (but not TRP) into body tissues such as muscle. This significantly increases the ratio of TRP to LNAA, thereby increasing its ability to cross the blood-brain barrier. This then leads to elevated levels of 5-HT, suppressing appetite and promoting relaxation (and drowsiness), and feelings of well-being.

Kaye et al. (1988) specifically addressed the role of brain serotonin in a study of nine women with BN. Six participants who voluntarily stopped bingeing and vomiting showed increased TRP/LNAA ratios, whereas the three who were stopped after four cycles did not (two of these stated that they would have continued bingeing and vomiting if they had not been prevented by the research team). They also measured plasma prolactin (PRL) as this has been shown to be a useful indicator of serotonergic neurotransmission (Markus, et al., 2000), and found that PRL levels were also elevated in the group that stopped voluntarily but not in the remaining three, suggesting increased serotonergic neurotransmission for the first group (although they also noted that this could be attributable to other factors such as gastrointestinal hormone secretion).

1.3.4.2.3 Neurocognitive factors

Research has been carried out on the role of neurocognitive performance in patients with BN, summarised in a literature review by Van den Eynde et al. (Van den Eynde, et al., 2011). A meta-analysis has established that difficulties in set-shifting (the ability to move repeatedly between multiple tasks) are to be found in patients with AN (Roberts et al., 2007), and another meta-analysis has supported the idea that poor central coherence (a bias towards detail with a tendency towards impaired integration of

information) is also a risk factor (Lopez, Tchanturia, Stahl, & Treasure, 2008). Poor central coherence is often associated with autism, and Russell (1979) has proposed that AN may itself be a variant of this condition. Individuals with EDs present a higher suicide risk (See 1.3.3 Mortality), and it has been suggested that a reason for this may be impaired cognitive function impacting on therapeutic efficacy (Zucker, et al., 2007).

According to Van den Eynde et al., the evidence for BN is less clear-cut. It is possible that disturbed neurocognitive performance seen in AN is related to changes in brain physiology caused by the condition. However, there is some evidence from twin studies challenging this explanation and further work is required to understand the relationship between BN development and neurocognition (Van den Eynde, et al., 2011).

1.3.4.2.4 Hormonal factors

Zehr et al. (2004) found an association between early-onset puberty and risk of EDs and anxiety in both men and women. They speculate that this may be attributable to the effects of gonadal hormones, and cite research correlating estradiol with food intake and ED symptoms. They also recognise that there may be psychosocial mechanisms accounting for this, although they consider this mainly in terms of general societal expectation of men, rather than specifically on early-onset puberty.

O'Dea and Abraham (1999) conclude that puberty is usually a more positive experience for boys than for with girls. They found that in contrast to a female desire to reduce weight, young adolescent males tended to embrace bodily change, wanting to develop their bodies in the belief that it improved sexual appeal. It is possible, however, that there is a sub-group of men who, either because they are resistant to leaving childhood or because they feel unable to meet these body ideals, are more anxious about puberty.

In women, it has been observed that fluctuations in BN symptoms are often related to the menstrual cycle (Rolls, Fedoroff, & Guthrie, 1991), and it has also been shown that decreased estradiol and elevated levels of progesterone are associated with

increases in binge eating (Edler, Lipson, & Keel, 2007). There is less evidence for the influence of sex hormones in male eating behaviours. It has already been noted that women who start puberty early have an increased risk of EDs, and there is some evidence for early or late pubertal development being a risk factor for BN in males (Kaltiala-Heino, Rimpela, Rissanen, & Rantanen, 2001). Further work is required for the role of hormones in male ED aetiology to be understood more clearly.

1.3.4.2.5 Stress-induced eating and emotional regulation

The role of stress in eating has formed the basis of a considerable body of research. Geliebter and Aversa (2003) have shown that overweight people report eating more when their mood is low, whereas underweight people eat less. Masheb and Grilo (2006) observed a correlation between items on the Emotional Overeating Questionnaire and binge frequency, ED symptoms and depression. They stated that severity did not appear to be related to BMI, but it should be noted that all participants in their study were overweight, so no corresponding information is available for healthy-weight individuals.

A number of studies have indicated that eating responses to stress are divided between those who appear to eat more and those who eat less. One showed 42% eating more and 38% less (Oliver, Wardle, & Gibson, 2000), while another US study has shown 43% using increased amounts (or unhealthier foods), with 36% avoiding meals in the previous month as a response to stress (APA, 2007). It is not clear whether these differences are due to individual differences or whether different phenomena are being observed.

Macht, Rothand and Elring (2002) have shown that when healthy men were offered chocolate under controlled conditions following exposure to films inducing sadness, anger, fear and joy, consumption and appreciation was increased when joy was experienced but reduced when sadness was felt. They posit two emotional eating responses to stress: “emotion-congruent modulation of eating” and “eating to regulate emotions”, and argue that the contrasts between studies that show low and high eating

responses to sadness may be due to different phenomena being observed. Macht, Rothand and Elring attribute this emotion-congruent modulation to a slowing of cognitive processes, reduced activity and a lack of external focus, resulting in decreased appetite. An increase in appetite is attributed to the use of food as a means of emotional regulation in an attempt to alleviate feelings of sadness and their associated unpleasant effects.

Another possible explanation for this may be the cortisol response to be found in different individuals when exposed to stress. Epel et al. (2001) found that participants with higher cortisol levels in response to stress tended to eat more than those with a lower response. Although there is no clear consensus, the literature seems to suggest that almost half the population has a susceptibility to eating more in response to stress or using eating as a means of emotional regulation.

1.3.4.2.6 Gender dysphoria

The exact causes of gender dysphoria are unknown, but a greater emphasis is now being given on biological factors over parental and family ones (Cohen-Kettenis & Gooren, 1999). DSM-5 defines gender dysphoria as:

....the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender (APA, 2013, p. 451)

The inclusion of gender dysphoria has resulted in the removal of "gender identity disorder, which had featured in DSM-IV-TR (APA, 2000, pp. 532-538), and prior to 2013 much of the literature uses this term. There is some qualitative evidence to suggest that gender dysphoria is linked with EDs, with male-to-female transsexuals experiencing severe body dissatisfaction and exhibiting ED symptoms (Hepp & Milos, 2002). Another qualitative study found that the majority of gender-identity disorder participants experienced disordered eating, either now or in the past (Ålgars, Alanko, Santtila, & Sandnabba, 2012). There is a need, however, for more quantitative research in this area.

1.3.4.3 Socio-cultural factors

A number of socio-cultural factors are also linked to the development of EDs. These include locus of control, body dysmorphia, gender role conflict, familial history of EDs, dysfunctional family environments and childhood sexual abuse. These are explored in the following sections.

1.3.4.3.1 Locus of control

Bruch has asserted that EDs often occur following a "desperate but futile struggle to establish a sense of control". She goes on to categorise the resulting EDs as a maladaptive "search for selfhood and self-respecting identity" (Bruch, 1978, p. 229). It has been argued that the need for control is innate rather than learned, suggesting that it has a biological basis (Leotti, Iyengar, & Ochsner, 2010). For many individuals with EDs, the need for control seems to stem from a perceived lack of it. "Control" covers a number of several factors, including degree of control over their everyday lives, control of their emotions, impulses and behaviours, and their ability to shape their future. This equates to the broad concepts of fatalism, self-control of impulses and social-political influence covered by Reid and Ware's scale (Reid & Ware, 1973).

Rotter (1966) conceptualised internal/external locus of control in the I-E Scale. It has since been shown that a strong external locus of control is a common feature of EDs, with Bruch drawing attention to the "ineffectiveness" felt by AN sufferers (Bruch, 1962, p. 187). There is an extensive body of literature arguing the benefits of a strong internal locus of control to such areas as academic achievement (Findley & Cooper, 1983), coping with stress (Lefcourt, Martin, & Saleh, 1984), and resolution of marital problems (Miller, Lefcourt, Holmes, Ware, & Saleh, 1986). Those with a strong *internal* locus of control are more likely to believe that people get the respect they deserve, that what happens to them is a result of their own doing, and that the average person is able to influence government decision making (Rotter, 1973)

Individuals with EDs often report feeling controlled by friends or family, with Williams, Chamove and Millar (1990) finding that compared with non-clinical controls, female participants felt more controlled, experienced more hostility directed towards them, were less self-assertive and experienced less familial encouragement towards independence. Similar findings were also made by Dagleish, et al. (2001), who found participants perceived themselves as having low-levels of control over events in the world, although they were more inclined to attribute negative events internally. This is a negative consequence of internal attribution of control, and has been observed in other ED studies. Watt, Sharpe and Atkins' (2002) study of college women found that loss of control was predictive of purging behaviours, but it also found that internal attribution of failure was predictive of restrictive eating. Tiggeman and Rothblum have found that overweight women with a strong internal locus of control have a higher propensity to low self-esteem than their normal-weight counterparts, and they attribute this to self-blaming associated with a failure in dietary restraint. However, it should be noted that a similar correlation was not found in the male participants in the study (Tiggeman & Rothblum, 1997).

More recently, Foran has looked at control from the perspective of emotional eating, with control-seeking forming a key part of her emergent theory. She points to the way that several of her participants use food as a means of control, relating it back to Brannon's gender roles (Brannon, 1976) and, "*....an expectation for men to be confident, self-reliant and in control*" (Foran, 2015, p. 138). Apart from this, the themes identified by Foran suggest that male needs for control are broadly similar to those experienced by women, including use of food to compensate for troubled home or work lives, providing self-soothing and something that can be relied upon. Halliwell (2002) has also observed in terms of appearance, that there seems to be a correlation between actual/ideal-self discrepancy and emotional eating, suggesting that an inability to control appearance results in compensatory behaviour.

1.3.4.3.2 Thin/fit ideal internalisation and body dysmorphia

Societal idealisation of thinness has been extensively explored in recent years in relation to EDs (see literature review by Keel & Forney, 2013). Feldman and Meyer refer to this as the “sociocultural perspective” that promotes body ideals that are unattainable for most people (Feldman & Meyer, 2007, p. 219). Problems arise when these societal standards and expectations become internalised (Thompson & Stice, 2001). Thompson et al. (1999) argue that thin ideal internalisation is linked to body-image disturbance in females.

There is some argument, however, that for men it is not thinness per se but rather an idealisation based upon muscularity and a desire to match up to a particular body aesthetic. (Morry & Staska, 2001). Halliwell's (2002) study on body image concerns through adulthood show some interesting distinctions between men and women. For men she found that weight concerns tended to increase with age, that they had a particular focus on conforming to similarity with their peers and not wanting to stand out. In particular, she noted that “whilst women focus on the body primarily as an 'object of display', men are concerned with the body's 'ability to do'” (Halliwell, 2002, p. 233). She also observes that younger men appear to have a great emphasis on muscularity. This is particularly important in terms of the differences in diagnostic criteria for EDs. Many individuals with binge/purge behaviours may be diagnosed with BN or OSFED when, with the exception of their BMI, their pathology most closely resembles AN. There is growing evidence that this internalisation acts as a moderator in male body dissatisfaction and eating disorder symptomology (Dakanalis, et al., 2015).

Often, this idealisation is linked to professions and recreational activities where particular body shapes are prized. Ballerinas have a high incidence of both AN and BN (Openshaw & Palmer, 2007; Özgen, 2009). Sportsmen and women are also a high-risk group, especially where there is an emphasis on athletic physique with low body weight/fat, a feature common to swimmers, track athletes and gymnasts. Milligan &

Pritchard (2006) report that body dissatisfaction is the primary cause of eating disorders among lean athletes.

Tiggeman has correlated female body dysmorphia with time spent reading magazines and watching television programmes portraying idealised body images (Tiggemann & Pickering, 1996; Tiggemann, 2003). This is supported by Harrison (2000) who, in a study of American school children, found that exposure to magazine images depicting thin body shapes is a significant predictor of BN in 9th-12th grade children. In contrast, she also found evidence of a correlation between BN and exposure to television programmes depicting obese body images.

Leit, Pope, & Gray (2001) undertook analysis of Playgirl centrefold images and found that they matched the tendency towards increasing muscularisation that has been observed in action figures (Pope, Olivardia, Gruber, & Borowiecki, 1999; Baghurst, Hollander, Nardella, & Haff, 2006). Leit et al. hypothesise that this tendency may be attributable to the growing use of anabolic steroids, although they also observe that:

....women have rapidly achieved parity with men in many aspects of life, including even military roles, leaving men with only their bodies as a distinguishing source of masculinity. (Leit, Pope, & Gray, 2001, p. 92)

If their hypothesis is correct, then individuals with low body self-esteem could be expected to struggle more with their perceived inability to live up to gender norms.

Body dysmorphia is strongly associated with the psychopathology of eating disorders (Fairburn & Harrison, 2003). The key difference between thin/fit internal idealisation and body dysmorphia is that in the former individuals are responding to a societal consensus of the body ideal whereas with body dysmorphia they are seeing flaws and defects in themselves that “are not observable or appear slight to others” (APA, 2013, p. 242). Tata et al. (2001) found that young adult women demonstrate significantly more disordered eating practices than men, and that men are more likely to indulge in excessive exercise, both behaviours being correlated with low body satisfaction and high weight perception.

1.3.4.3.3 Male gender role and gender role conflict

Thompson Jr and Pleck (1986, p. 531), in describing gender-role norms (they use the term “sex role”), distinguish between descriptive norms (how individual men are characterised) and sociocultural norms (the idealised characteristics that society expects men to exhibit). Their 3-factor model associates the male gender role with status, toughness and anti-femininity. These equate to the four male-role norms identified by Brannon and Juni (1984), which include anti-femininity, achieving status, independence and self-confidence, and aggressiveness. Finally, O’Neil, Helms, Gable, David & Wrightsman (1986, pp. 344-345) identify “success, power, competition”; “restrictive emotionality”; “restrictive affectionate behavior between men”; and “conflicts between work and family relations” as the four key items within their gender-role conflict scale. It should be noted that what constitutes masculinity and femininity (and, therefore, androgeneity) varies widely between cultures, and most research adopts a Westernised perspective on this (Galdas, Cheater, & Marshall, 2005).

It has been suggested that some aspects of these gender-role norms may lead to “gender role conflict”: negative effects on individuals or others arising from these norms (O’Neil, Helms, Gable, David, & Wrightsman, 1986). Among the most damaging of these is the tendency for men to avoid seeking medical or psychological support. Wills and DePaulo (1991) have found that North American men are only half as likely to seek counselling as women, and it has been argued that the characteristics associated with seeking psychological support (e.g. a willingness to recognise and address personal problems, self-disclose and accept vulnerability) run counter to those associated with traditional male social norms (Good & Wood, 1995). It is not surprising, therefore, that gender-role conflict is itself linked to lower psychological wellbeing (Sharpe & Heppner, 1991). McCreary, Saucier and Courtenay (2005) have shown a correlation between male-type traits and a need to be muscular, and that men exhibiting these traits struggled more with living up to societal expectations. Similarly, Schwartz & Tylka (2008) have found that gender role conflict is positively associated with lower body satisfaction.

The relationship between gender-role conflict and sexuality has also been the subject of research. Numerous studies have shown that many gay men embrace societal masculine norms and respond negatively to what they perceive to be effeminacy in other men (Taywaditep, 2001; Sánchez & Vilain, 2012). This, in turn, manifests itself in gender-role conflict for gay men, with many wanting to be more masculine than they feel they are (Sánchez, Westefeld, Liu, & Vilain, 2010). When understanding the relationship between gender-role conflict and eating disorders in gay men, body-dissatisfaction appears to be the key mediating factor (Blashill & Vander Wal, 2009). Given that body-dissatisfaction seems to be more widespread among homosexual males, this may explain why EDs are also more prevalent in this group than in heterosexual males (French, Story, Remafedi, Resnick, & Blum, 1996). Since body-dissatisfaction is linked to a drive for muscularity in both gay and heterosexual men (Duggan & McCreary, 2004), it seems likely that heterosexual men with high levels of gender-role conflict are equally susceptible, although there appears to be insufficient research with heterosexual male subjects to support this hypothesis.

1.3.4.3.4 Familial history of EDs

A number of studies indicate the likelihood of familial transmission in EDs, and it is likely that parental concerns with diet and feeding are symptomatic of transmission of partial syndromes. Strober et al. (2000) found increased frequency of AN, and even more so of BN, in participants with first-degree relatives who also exhibit ED symptoms. Of particular interest is the fact that BN frequency was more associated with a familial history of AN than BN, suggesting that these two conditions are closely linked. In their study of 177 BN sufferers and 190 first-degree relatives, Stein et al. (1999) found that forty-three percent of sisters and twenty-six percent of mothers of BN patients also had a lifetime ED diagnosis. It is interesting to note that there was no significant male familial history for any of these participants. This may suggest that men are less susceptible to familial transmission of EDs than women. A comparatively unusual route into BN

behaviour has been shown to occur through observing the bulimic activity of other family members and acquaintances. In a qualitative study of BN subjects, Jeppson et al. (2003) presented evidence of family and extended-family members actively promoting bulimic behaviour to other family members.

1.3.4.3.5 Family environments and parental dysfunctionality

Studies show that relatives of BN participants have an increased risk of an eating disorder such as BN or AN. The genetic implications of this have already been discussed (See Section 1.3.4.2.1), but as we have seen with emotional models of EDs (see Section 1.3.4.1), parent-child relationships are important, with much learning taking place within the family environment. This can be as simple as family approaches to the serving of food, as there is evidence to suggest that children adapt the amount they consume to the food available (Savage, Fisher, & Birch, 2007), and that this is also evident in adulthood (Rolls, Morris, & Roe, 2002). Rolls et al. found that in adults, the plating of food, rather than allowing individuals to serve their own portion, had no effect, but this may be because there is a moderating effect of sharing a serving dish with others. It seems likely that individuals will be less inhibited about consuming all the available food if they are not having to share it. If this is the case, then plating of food, rather than allowing individuals to serve themselves, could still be a risk factor.

The requirement of Clive and Michael to finish their food is an example of food rules, which are linked to susceptibility to bingeing and restricting behaviours, potentially developing into full-blown EDs (Puhl & Schwartz, 2003). That finishing of food is also seen as a demonstration of love, serves to add an additional element of negative parenting that may result in increased anxiety.

Sometimes the family environments can be significantly dysfunctional. This is something that is often reported by BN patients, but the objectivity of these assessments remains unclear, and it is uncertain whether any such dysfunction was causal or caused by the BN. Johnson, Cohen, Kasen and Brook (2002), in a longitudinal community study

looking at the relationship between childhood adversity and EDs, concluded that maladaptive parenting may play a significant role in ED development. They also found elevated levels of EDs in children from single-parent families, something also confirmed by Martínez-González, et al. (2003) in a Spanish community study. This has been attributed to a lack of parental time available to educate children in healthy diet and nutrition (Wichstrom, 1995; Smolak, Levine, & Schermer, 1999).

Mintz et al. found slightly higher rates for BN among participants with alcoholic parents when compared to a control, but regarded parental alcoholism and EDs as only “minimally related” (Mintz, Kashubeck, & Tracy, 1995). It is more likely that it is the abuse itself that is significant, with emotional control and abuse seen as a more significant predictor than physical abuse (Kent, Waller, & Dagnan, 1999; Waller, Corstorphine, & Mountford, 2007).

Recent work by Young, McFatter, & Clopton (2001) suggests that family functioning is a poor predictor of BN, although Hastings and Kern (1994) speculate that the association may be more valid where sexual abuse is involved. This supports the findings of Hudson and Pope (1992) who in reviewing existing literature concluded that there was a body of evidence to support childhood sexual abuse as a significant risk factor for BN (whether occurring inside or outside the family). Deep et al. (1999) have also found evidence of higher incidence of substance dependence among bulimic women with a history of sexual abuse.

Finally, there is evidence to suggest that dysfunctional family environments can be a source of shame for individuals with EDs. In a study of women with BN, Murray, Waller and Legg (2000) showed that internalised shame acts as a mediator between paternal over-protection and BN attitudes and behaviours. Shame in general is associated with EDs, with studies such as Frank (1991) showing that women with EDs experience more shame and guilt than normal or depressed women.

1.3.4.3.6 Parental intrusiveness and feeding styles

Parental intrusiveness may be linked to the development of BN, with Rorty et al. reporting participants citing “maternal invasion of privacy”, “maternal jealousy and competition”, “paternal seductiveness”, and specifically maternal and paternal “overconcern with daughter’s eating, weight and shape” as key factors (Rorty, Yager, Rossotto, & Buckwalter, 2000). Frequently this takes the form of negative comments or teasing (Phares, Steinberg, & Thompson, 2004). La Mela et al. (2015) have demonstrated a correlation between perceived criticism, parental expectation and BN symptoms. The emphasis should be on *perceived* parental intrusion as it is not always possible to measure the actual degree of intrusion.

There is also a body of evidence to support the notion that parental feeding styles play a key role in the formation of child and adolescent feeding behaviours (Golan & Crow, 2004). The correlation between overconcern with diet and shape and BN behaviours is demonstrated by Moreno and Thelen’s (1993) study of female undergraduates which showed that mothers of children with BN and subclinical BN were more likely to restrict food intake and/or encourage diet and exercise when compared with the non-bulimic group. Bruch (1955) has also suggested that parents can over-imbue mealtimes and food with emotional significance, resulting in an over-reliance on food as a means of emotional regulation (see Section 1.3.4.1.2).

1.3.4.3.7 Childhood sexual abuse

Rorty, Yager and Rossotto (1995) have found higher rates of sexual, physical and psychological abuse among women with lifetime histories of BN when compared with a control group with no history of EDs. Kendell-Tackett (2002) has observed that evidence for a relationship between childhood sexual abuse (CSA) and EDs is mixed. In a study by Hall et al. (1989), fifty percent of AN and BN sufferers reported prior sexual abuse (in some instances in adulthood). A different view is given by Pope and Hudson (1992), however, whose meta-analysis concludes that higher rates of BN are probably

attributable to methodological problems, and that the overall CSA rate among BN sufferers is no higher than that found in the general population.

There are particular difficulties associated with obtaining data for CSA among men, foremost of which is the issue of shame. Men are less likely to report EDs than women, and when they do, they are equally reluctant to report CSA, or adult abuse. It has also been suggested that because men are more commonly the perpetrators of sexual abuse, there is a greater risk of males developing problems relating to sexual orientation and/or expression (Strother, Lemberg, Stanford, & Turberville, 2012).

1.3.5 Mental health support for men with BECB/EDs

A Google search using terms such as “men/male”, “eating disorders”, “NHS” produces no responses from the public sector specifically targeted at men. The NHS Choices pages for eating disorders demonstrates that effort has been made recently to raise the profile of men with EDs. Although the primary image used is of a young woman, the language used is gender neutral, and towards the bottom of the page there is a link to a video for “Steve’s story”, a personal account of male bulimia (NHS, n.d.). Web pages for specific NHS eating disorder services also tend to be gender neutral, although in the rare instances where photographs are used, they tend to be of women (either patients or staff members).

There is very little literature globally looking at male experiences of treatment for EDs, let alone within the UK. A recent meta-analysis found only four qualitative studies, two of which were UK-based (Thapliyal & Hay, 2014). De Beer and Wren (2012) provide a meta-analysis of male ED treatment within the UK, with special reference to the results of De Beer’s unpublished qualitative study of nine UK men. De Beer and Wren observe that the sex of the therapist seems to be of less importance to men in treatment than the recognition of their maleness:

There seems to be a clear need not for a gender-neutral service but for a gender-sensitive service”. (De Beer & Wren, 2012, p. 433)

This comment contrasts to the experience of gender insensitivity to be found in some personal accounts of treatment (see Section 1.3.8).

Robinson et al. (2013) in a UK qualitative study of eight male ED patients found conflicting views on the importance of gender in treatment, although they report participants experienced mistargeted treatment and feelings of exclusion in groups primarily made up of female patients. A particular characteristic of these two studies is that they were both conducted within NHS ED services. As such, they represent the experience of men who have been referred to specialist centres of expertise. They do not include the experiences of those who are either referred for more general psychological support or who do not seek professional help at all. Taken with evidence from individual accounts of treatment for EDs (see Section 1.3.8), it seems that specialist NHS ED services adopt an apparently gender-neutral approach that largely fails men because it is based on treatment protocols devised using the experience of working with a female population, and because men feel alienated as a consequence of being in such a minority within a group environment.

1.3.6 Quantitative studies of men with BN and BED

There are very few quantitative studies focussed exclusively on men with BN. An advanced search of thesis abstracts in the British Library ETHOS catalogue using the terms “men” or “male”, “bulimia” and “quantitative” produced no results. There are a small number of studies that have been published, including comparisons between male and female groups, and the findings of some of these are discussed below.

Schneider and Stewart Agras (1987) carried out a matched comparison of fifteen males and fifteen females with BN, employing the Beck Depression Inventory, the Assertion Inventory, the Eating Attitudes Test (EAT), Eating Disorders Inventory (EDI) and the State-Trait Personality Inventory. They found no significant differences on the mean scores between these groups for any of the inventories, but did notice lower scores for men on the EAT and EDI, suggesting less preoccupation with food and a lower drive

for thinness. This study also included in-depth interviews, and the authors reported participants admitting to embarrassment about attending clinics for treatment, as well as inconsistency in attending appointments. Although Schneider and Stewart Agras comment on the greater risk of BN in homosexuals, they do not give a breakdown of the sexual preferences of their participants.

Olivardia, Pope Jr, Mangweth, and Hudson (1995) used mixed methods (structured interviews and psychometric tests) to compare twenty-five college men with ED diagnoses (equating to those newly-proposed for DSM-IV) with 33 women with BN. Thirteen of the men the proposed diagnoses for BN, two for AN, four for both BN and AN, and six for the proposed BED diagnosis (although subsequently this was not included in DSM until DSM-5). They found broad similarities across genders, but noted that there was a significantly lower tendency of men to seek help when compared with the bulimic women. They also noted higher rates of psychiatric co-morbidity compared to men without EDs

Woodside et al. (2001) conducted a community study of men with full or partial EDs with comparison groups of females with EDs and men without. This study also confirmed the clinical similarities between male and female ED groups. Both ED groups showed higher psychiatric comorbidity and lower quality of life when compared with the non-ED group, and a similar ratio of BN to AN.

Eliot and Baker undertook a study of forty adolescent males with EDs (only 12.5% with BN, although a further 32.5% were diagnosed with EDNOS with many of these being likely to fall within a BN/BED diagnosis under DSM-5). They found a similar trajectory for EDs when compared with the findings of their female group. However, their ten-year follow up yielded a response rate of only 10% (n=4), leading the authors to comment on the general difficulty of long-term follow-up studies, but particularly among men who they perceive as being reluctant to respond with information about what they regard as a “preponderantly female disorder” (Eliot & Baker, 2001, p. 541).

Fernández-Aranda, et al. (2009) studied treatment outcomes for nineteen men with EDs (12 with BN and 7 with EDNOS), comparing them to a female ED control group. They reported that gender predicted lower mean scores on the EAT-40 scale, and lower symptomology than women following treatment. However, at one-year follow-up, the probability of having BN or EDNOS was higher for men than for women. A key observation relates to the EDI scales used and what they are actually measuring. They observed lower body dissatisfaction for men, and questioned whether the concepts concerning eating and shape are the same across genders (for example, with men showing greater concern for muscularity than for thinness).

Overall, the difficulty in recruiting male participants seems to lead many studies to focus on men with EDs in general, rather than focussing on specific types of ED, such as BN. The lack of community studies is particularly problematic as the unwillingness of men to come forward for treatment means that studies based upon clinical populations may not be representative of the male ED population as a whole.

1.3.7 Qualitative studies of men with EDs

More recently, there has been an increased emphasis on qualitative approaches to ED research, focussing on the experience of those living with BN. These studies constitute an important and growing body of material. Shillito's (1993) work examines women's accounts of recovery. *Sensing the Self*, Reindl's (2001) seminal book, focusses on a similar theme. Southard's (2008) doctoral dissertation looks at patients' experiences of bulimia within the context of race, culture and family, while Nakamura (2012) examines BN within the context of Japanese culture and the contribution of recovery narratives to the recovery process.

With the exception of Nakamura's work, which features a mixed, predominantly female sample, all these qualitative studies focussing on BN utilize female participants only. Other studies have shown similar trends, some associated with specific male subgroups (such as gay men) where there may be similar socio-cultural pressures in

terms of body image to those found among women (Russell & Keel, 2002). The increasing incidence of BN among men means that their voices also need to be heard, particularly if we are to understand possible gender differences in the onset and progression of BN.

Although studies of men with BN and BED are relatively sparse, there is a growing body of material looking at male self-image which provides useful insights into men with EDs. A feature of studies looking at male experiences of body image is a discrepancy for many between what they perceive to be societal ideals for male physique and their own body shapes. A key finding for Augustine is what he refers to as “conflict and masculinity”, emphasising,

“the importance of body image in the construction of a masculine identity whilst at the same time body image was experienced as ‘non-masculine’” (Augustine, 2010, pp. i-ii).

Markham has observed a similar phenomenon, with participants expressing a perceived failure to conform to their peer group, and in particular, a “childhood failure to succeed in achieving society’s pressure to reach ‘maleness’” (Markham, 2013, p. 74). Markham observes that individuals either respond by trying to conform to societal ideals, often by participating in sport to reshape their physique, or in some cases to detach as a means of protection against bullying. Markham observes that eating behaviour is one of the areas influenced by these body-image concerns.

Spyrou’s thesis, examining men’s experiences and understanding of BED, also highlights feelings of isolation and confusion associated with having what they perceived to be “a female and/or homosexual disorder”. Participants also talked of wanting to adhere to masculine stereotypes, and described having BED as “unacceptable and emasculating” (Spyrou, 2014, p. 7). Studies have shown that gendered constructions of EDs can lead to delayed help-seeking by men (Räsänen & Hunt, 2014), but as Spyrou reveals, even when they do seek help men often find that it is inadequate or non-existent.

The emphasis of such studies has been on those who have sought help and are “recovered”, thereby focussing on what the researcher, rather than the participant, thinks

constitutes recovery. The focus on recovery from BN has tended to side-line the insights that those with long-term BN, or only partial remission, may have to offer. Rather than seeing recovery as a cut-off with clearly-defined criteria (DSM 5 suggests criteria for “full” and “partial” remission (APA, 2013)) there is a need for studies placing the emphasis on the progression of the condition over an extended period. This could help to provide a more complete picture of the significant events and/or interventions that, from a BN-sufferer’s perspective, have either helped or hindered recovery.

1.3.8 Published (or self-published) accounts by men with experience of living with BN.

Along with the growing shift in emphasis towards the use of patient narratives in male ED research, there has also been a growth in publishing of personal accounts from BN sufferers, all of which help to provide alternative insights into BN. These have utilised a variety of different media, with men blogging about their experiences, authoring accounts and publishing videos online. The press has also begun to take more of an interest, with newspaper articles and programmes exploring male experiences of EDs. This is in spite of the sense of shame frequently associated with EDs (Frank, 1991). These accounts reveal a wide variety of pathways into EDs, and BN in particular. The following accounts are primarily focussed on male experiences of BN, although they include accounts from AN sufferers, either because they fall into the binge/purge subtype, and therefore have much in common with BN sufferers, or because they are representative of experiences common to many men suffering from EDs.

Not all personal narratives look to events from childhood or adolescence as the root cause of EDs. Often it is pressures related to sport which seem to serve as the trigger. The cricketer Freddie Flintoff speaks of always having experienced difficulty controlling his weight, and turning to vomiting as a means of controlling it. Although Flintoff has talked openly about mental health issues, childhood experiences of bullying and low self-esteem, his need to curb his weight as a professional sportsman appears

to be the primary motivator leading him to develop BN rather than just having bingeing episodes (Brooks-Pollock, 2014; Flintoff, 2015). Although not a professional sportsman, Tom Fairbrother is a committed amateur athlete whose AN was triggered by advice from a fellow athlete to lose weight in order to improve his times (Fairbrother, 2016). Scot Simon has written a brief monologue highlighting his personal struggle with BN and AN, associated with his participation in school sports and characterised by comorbidities, including bipolar disorder, obsessive compulsive disorder and substance abuse (Simon, 2006). Doug Erlandson's account is also characterised by its association with exercise, as well as the association between AN and BN (Erlandson, 2012).

For Simon, the trigger was joining a gym with a friend and receiving a massage from a sports nutritionist. Simon describes her discussion of foods and calories causing him to obsess about food and initiating his AN (Simon, n.d.). Flintoff, Fairbrother and Simon exhibit symptoms more characteristic of the binge/purge subtype of AN, but all indulge in purging behaviours, including excessive exercise and vomiting. The focus is on physique rather than weight-loss per se, and it is likely that Flintoff would have fallen within the criteria for OSFED since his weight always seems to have been within a normal BMI. This focus on physique is also demonstrated by Dominic who, although regarding himself as having conquered his AN, has used body-building as a focus for emotional control (Dominic, n.d.).

Another common theme in these narratives is bullying. Brand reports bullying as a primary trigger of his bulimia:

I'd got all fat; when I started to get bullied at school as a result, I thought there must be a simple solution, and it turned out there was – eat loads and then puke it out. (Brand, 2008)

Although he doesn't link it to his ED development, Flintoff reports being bullied as a child because of his interest in cricket, comparing himself to Billy Elliot (Flintoff, 2015). Sam ascribes his bullying to being "geeky", although it became increasingly homophobic in response to his voice and appearance (Sam, n.d.). Andrew does not explicitly mention bullying, but he talks of:

...the mental recordings of “things kids said to me in elementary school” played over. (Andrew, n.d.)

He refers to his anxiety and the way managing food became an integral part of his distorted thinking. Cuban also reports being bullied as a child. Having torn his trousers from him on one occasion, forcing him to walk home in his underwear, his attackers were heard to shout:

“Hey Cuban. When you get some new pants, get a bra while you’re at it.” (Cuban, 2013, p. 36)

In this instance the bullying is physical and accompanied by taunting targeted at undermining his sense of gender identity.

Parents are a common theme within personal accounts, often being cited as a contributory factor in the development of EDs. Parental aggression is frequently mentioned. Sometimes, this aggression seems to take the form of critical or bullying comments. Cuban (2013) reports having a difficult relationship with his mother who would frequently denigrate his appearance and intellect. Dominic describes having a “neglectful father and overprotective mother” (Dominic, n.d.). Neglect is a stark feature of Steven’s account, describing himself as being “deliberately starved” by his parents, resulting in him being placed in foster care (Steven, n.d.). For Craig, his decision to stay with his father after his mother left home was to lead to him becoming a focus for his father’s anger and disappointment (Craig, n.d.).

Parental attitudes to food occasionally feature in personal accounts. Craig recalls his mother saying to him:

The times your Dad was away on ship I would always make you and your sister dinner but none for myself. Maybe you picked it up from me? (Craig, n.d.)

Craig identifies with his mother’s behaviour and personality, and having immersed himself in psychology quotes Bandura (Bandura, 1977) on learned behaviour. Some accounts also refer to familial experience of EDs. Walen (2014) reports that his mother had suffered from AN and would frequently engage in bouts of dieting and binge eating.

Craig's account also introduces parental absence, with his father's lengthy periods at sea being a feature of his childhood. This was later reversed when his mother left his father, leaving him to remain with his father, feeling that he needed to be taken care of (Craig, n.d.). Sam also refers to having an absent father, moving South from Liverpool in an attempt to form a relationship with him in adulthood (Sam, n.d.).

Many accounts describe interactions with health professionals. Most are in the context of help-seeking, although Tom Fairbrother recounts being challenged by his dentist because of his dental erosion caused by vomiting (Fairbrother, 2017). Some accounts, such as Andrew's, are positive. Initially suffering from AN, he describes being "scared" into eating normally, but this seems to have led to BN, resulting in him finally receiving successful in-patient treatment as part of a specialist programme (Andrew, n.d.). Simon also recounts helpful interventions by his GP, psychiatrist and specialist ED clinic, placing particular emphasis on the benefits of being able to speak to supporters in recovery from their own ED (Simon, n.d.).

Often, initially responsive support from health professionals can go badly wrong. After seeking help from his doctor, Sam received a next-day CAHMS appointment, only to be told that he needed parental consent because he was under 18. Their decision to contact his mother against his wishes had a detrimental effect on his trust for health professionals (Sam, n.d.). Daniel appears to have been fortunate in having a GP with sufficient perception to identify BN as the underlying cause of his pneumonia. This was subsequently undermined by a psychologist asking him if he was gay:

I felt that I could not seek treatment and that straight men could not admit to being anorexic or bulimic because it was not a heterosexual man's disorder. (Daniel, n.d.)

This emphasises preconceptions among medical professionals concerning gender, sexuality and EDs. Warburton recounts the experience of a young man with AN:

He added that most of the treatment is geared towards women, with one nurse even jokingly asking if he'd started his period yet. He said: "One of the first things they would ask is, 'Do you feel as if you were born a male?'" (Warburton, 2015)

The allusion to gender dysphoria seems to underline that many health professionals themselves subscribe to the view that EDs are a female problem, and joking about the ED by questioning his maleness displays an extraordinary lack of empathy. It demonstrates a negative bias towards male ED patients, the questioning of male identity riding roughshod over a key area of sensitivity for male ED sufferers, many of whom experience confusion concerning their sexuality and gender identity. John Prescott's experience appears to have begun well, with a referral to a consultant by the House of Commons doctor. The consultant seems to have deterred him, however, by asking "daft" questions concerning his childhood and early sexual history (Prescott, 2008, p. 231).

Many of the accounts are only negative. Steven recalls seeking help from an army psychiatric nurse after a tour of duty in Afghanistan. Her promise of a referral was not followed up, however, and Steven had no further engagement with medical professionals (Steven, n.d.). For Sam, the experience involved being put on a waiting list for counselling and having his GP's attention focussed on his depression, with very little interest in his BN (Sam, n.d.).

1.3.9 Summary of literature review

Overall, the literature shows that there are a broad range of factors contributing to the development of EDs, and BN in particular, in both men and women. The few comparative studies that do exist indicate that there is broad similarity in symptomology between men and women, but that men appear to exhibit less focus on slimness and more emphasis on muscularity. They also seem to be less inclined to come forward for treatment, which in turn seems to impact on the quality of clinically-based studies. The lack of comparative studies and community-based studies, and the difficulty in recruiting samples sufficiently large and representative, remains a challenge to those seeking to develop a more targeted approach to treatment.

1.4 Research Contribution and Rationale

Despite the growth in self-publishing, there is still a lack of material looking at EDs from a male perspective, and even less focussed on BN and BED. A significant majority of the research in BN that does exist has been of a quantitative nature. As well as demonstrating the prevalence of BN, other studies, such as Herzog, et al. (1999) have conducted longitudinal studies looking at recovery and relapse. Other studies have examined the efficacy of different treatment models (Shapiro, et al., 2007). Comparatively little qualitative research has been undertaken from the perspective of those living with or recovered from BN. Most existing studies are drawn from populations outside the UK. Nearly all are based on female participants with few exclusively male studies. Given the increasing prevalence of BN among men in the UK, there is an urgent need to give further voice to their experience of its onset and progression, acknowledging their own definitions of what constitutes recovery, and understanding their perspective on what helps and/or hinders this.

1.5 Contribution to Counselling Psychology

The accounts gathered for this thesis provide a unique perspective not only on male experience of BN, but also how they engage (or don't engage) with mental-health support services. The literature highlights differences in male presentations and experiences of BN which do not seem to be reflected in provision of tailored service provision to meet their needs. The focus on male lived experience contained in this study has the potential to facilitate a greater understanding of the male perspective, helping to inform approaches to the treatment of BN within counselling and clinical psychology, possibly resulting in a more positively-gendered approach to ED services.

Chapter 2: Methodology

2

2.1 Introduction

This chapter begins with a description of the research design in the context of the overarching research question. This is considered within the context of the development and purpose of the study, before considering the philosophical paradigms underpinning it and accompanying methodological considerations. This is followed by a discussion of the procedure used, including selection of participants, sample size and demographics, inclusion and exclusion criteria, recruitment, and data collection. It then goes on to discuss the process of data analysis before concluding with a discussion of ethical considerations, reflexivity, and quality and validity.

2.2 Research design

2.2.1 Research question

The broad research question used for this study is “How do men experience binge eating and associated compensatory behaviours (BECB)?” This is broken down into a number of sub-questions, adapted from Beresin, Gordon and Herzog (1989), Shillito (1993) and Reindl (2001). The semi-structured interview schedule arising from these can be seen in Appendix A.

It was anticipated that in discussing their experiences of living with BECB, participants would be likely to discuss such issues as causality, onset, progression and recovery. No assumptions were made concerning the meanings of these terms, and participants were encouraged to explore their own understanding of them. While this study was interested in how participants accounted for their recovery (or failure to

recover) from BECB, it was also concerned with how they interpreted and experienced these concepts.

There were, however, several other assumptions made for the purposes of the study:

- That men responding to the call for participants would be willing to talk openly about their experiences.
- That men might respond more positively to sharing their experiences with another man.
- That given that there is evidence that men are reluctant to seek help for their ED, there might be a similar reluctance to participate in this study. This could lead to a self-selecting group, not fully-representative of male experience.
- That BECB represents a set of phenomena that exist, and that individuals exhibiting the associated behaviours are able readily to identify with them.
- That participants responding to the call are more likely to consider their BECB as problematic, given the recruitment methods used (see Section 2.5.1.3).

It also became apparent during the study that I had been naïve in my assumptions concerning the term “male”. Although I did not retrospectively alter the inclusion/exclusion criteria, the sample group came to consist of individuals who were born biologically male and had not undertaken any form of gender reassignment (see Section 2.5.1.2).

2.3 Development and purpose of the research

My interest in eating disorders was originally sparked by my eldest daughter’s development of BN as an adolescent. While undertaking my conversion MSc in psychology, I wrote an extended essay examining the evidence for BN as an addictive behaviour. As my interest developed, I recalled other friends who had exhibited symptoms of disordered eating, many of whom were interested in my work and were willing to share their experiences with me.

When contemplating possible research topics, I considered making BN the focus for my doctoral thesis. My daughter was by now largely recovered, although she still retained a complex relationship with food. I was sensitive to her feelings about me choosing BN as a research topic, but she was supportive. My decision to focus on men was partly based on self-protection: I felt that studying the development of BN in women might be too close to my personal experience. In retrospect, my belief that studying men would be more protective was naïve and of limited benefit.

My main reason for choosing men, however, was the comparative lack of studies looking at male experience of EDs, and BN in particular. In the third year of my doctorate I began working within a specialist ED team and was struck by the lack of male clients (approximately 95% were female). This added to my desire to obtain more information on how men with EDs perceive help-seeking, and their experiences when they do engage with mental health professionals and other support services. Because the primary focus of my research was experiential, it lent itself to a phenomenological approach, and in particular, to Interpretative Phenomenological Analysis (IPA) (Smith, 1996).

2.4 Philosophical paradigm

Madill, Jordan and Shirley (2000) have emphasised the importance of explicitly stating the ontological and epistemological stances adopted in qualitative research. My ontological stance conforms to what has been described as “subtle realism” (Duncan & Nichol, 2004). This proposes that independent realities exist but that we do not have direct access to them. Instead, we must rely on our constructed representations of social phenomena, meaning that subtle realism is compatible with constructionist-interpretivist epistemologies in a way that naïve realism is not. Subtle realism is closely related to critical realism. Both share an assumption that real world objects exist independently of the human observer. However, subtle realism places an emphasis on our knowledge of reality through our own experience of it, rather than through the wider critical examination

of it proposed through critical realism (Guba & Lincoln, 1994). In practice, this distinction is not that great as I am completely open to that wider critical examination but am aware that my understanding of the knowledge it brings me is framed by the way in which I experience it, which may be very different to another individual.

The epistemological stance I have adopted is one of constructivism-interpretivism (Ponterotto, 2005), a relativist position which acknowledges the reflexivity of the researcher and the possibility of multiple constructed realities (Schwandt, 1994). Although relativism has been criticised for allowing multiple accounts to claim equal legitimacy (Murphy, Dingwall, Greatbatch, Parker, & Watson, 1998), IPA recognises the interaction between the researcher and participant, a process that is intrinsic to constructivism-interpretivism, as findings are jointly created and interpreted by the researcher and participant. The interviewer is as much a part of the interview process as the interviewee, and while the researcher will aim to empathise with the participant and, as far as possible, see the world from his or her perspective, the outcome will, in reality, be a co-construction (Ponterotto, 2005).

2.4.1 Methodological considerations

2.4.1.1 Qualitative versus quantitative approach

The focus of this study is the individual experience of living with BECB. Smith summarises the purpose of qualitative research as

....exploring, describing and interpreting the personal and social experiences of participants. (Smith & Osborn, 2008, p. 2)

It is not generalisable to populations. Nor is it predictive, being more interested in processes than outcomes, and therefore requires a different approach to quantitative research (Willig, 2008b).

2.4.1.2 Interpretative Phenomenological Analysis

Although focussed on a specific target population, the research question was deliberately broad in order to avoid constraining the responses of participants. It was not

the intention of this study to employ selective sampling as a means to generate hypotheses, an approach more in keeping with grounded theory (Willig, 2008b). Instead it was conducted using IPA (Smith, 2004; Smith & Osborn, 2008).

The decision to use IPA rather than grounded theory was based primarily on the desire to understand the experience of living with BECB as completely as possible from the participants' perspectives rather than to generate theory on the basis of this experience (Charmaz, 2008). The emphasis on phenomenology precluded the use of other qualitative approaches, such as narrative psychology (Murray, 2008) or discourse analysis (Willig, 2008a).

Phenomenology is a school of philosophy established by Edmund Husserl in the nineteenth century, and can be regarded as an approach to the study of human experience (Smith, Flowers, & Larkin, 2009). Husserl drew a distinction between experience per se and the insight derived through reflection. For him, consciousness is achieved through the understanding of subjective experience (Husserl, 1927). Phenomenology also draws upon Heidegger's concept of "in-der-Welt-sein" or "being in the World" (Langdridge, 2007). This means that the participant's experience encapsulates their relationship with other people and objects, and their place in the World about them, as well as their consciousness.

Smith et al. summarise the contribution of phenomenology to psychological research as follows:

For psychologists, one key value of phenomenological philosophy is that it provides us with a rich source of ideas about how to examine and comprehend lived experience. (Smith, Flowers, & Larkin, 2009, p. 11)

To understand this lived experience, it is necessary to "disengage from the activity and attend to the taken-for-grantedness of it" (Smith, Flowers, & Larkin, 2009, p. 13). Because of this process of reflection, the application of phenomenology in psychology research necessarily requires the study of individual experiences. The individual nature of the reflective process required is the essence of its subjectivity.

In developing IPA, Smith has created a systematic approach to the application of phenomenology to qualitative research. Inevitably, this process requires subjects to engage in this process of reflection to achieve consciousness. Consequently, we are achieving insight through their reflection on their experience, rather than through direct access to the experience itself. This methodological approach is therefore compatible with my ontological stance. Our understanding and knowledge of the reality under discussion can only be increased if the participant accounts are reliable and trustworthy, and my interpretation of them robust. It is with respect to this point that Smith draws attention to what he calls the “double hermeneutic” at play in IPA in pointing out that whilst the “participants are trying to make sense of their world, the researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn, 2008).

Ideally, my preconceptions should not be allowed to impinge upon the research process, but in practice we can see that it would be naïve to think that this was possible. By acknowledging the double hermeneutic, IPA allows for the role of the researcher in the research process. This study is concerned with individual experience, and I hope that my presence within it can be helpful when recognised and openly acknowledged.

2.5 Procedure

2.5.1 Participants

The study was based on a sample of nine participants using a purposive sampling strategy to ensure a rich body of material for the analysis (Polkinghorne, 2005). In addition to the inclusion/exclusion criteria used (see below), the following considerations informed the choice of participants for the study:

- Length of time since commencement of the eating problems. A sufficient amount of time was required to allow participants to reflect back on their experience of BECB. Five years was the minimum stipulated in the

inclusion criteria but preference was given to those with longer perspectives.

- Type of compensatory behaviour used. The study aimed to gain experience of as broad a range of compensatory behaviours as possible, including exercise, dieting, vomiting and use of laxatives/medications.
- A balance between participants from urban and rural settings. There is some evidence to suggest that BN is up to five-times more prevalent in urban populations than rural (van Son, van Hoeken, Bartelds, van Furth, & Hoek, 2006). Including participants from both groups was intended to provide a broader range of experience.

In practice, difficulties experienced in sourcing participants meant that these criteria were not used to exclude participants. Nevertheless, their objectives were broadly achieved, although three participants were aged 21 or younger.

2.5.1.1 Sample size and demographics

The sample consisted of eight participants, aged from 19 to 54 (mean = 34.75 years, SD = 13.42). Five were in full- or part-time employment, one was an undergraduate student, one was unemployed and one retired. All eight were British citizens identifying as “White British”. Four identified as heterosexual, and four as homosexual. Two had been educated to secondary-school level, six to degree level, and one to post-graduate level. One had received a formal diagnosis of AN, and five of BN. Three had received formal treatment from a specialist NHS eating-disorder service while six had received non-specialist psychological therapy. Three were in therapy at the time the interviews took place. Six regarded their weight as having been “stable” or “moderately stable” over the last six months, with one regarding it as “moderately unstable” and one as “very unstable”.

IPA as a methodological approach assumes that the sample will be sufficiently homogeneous in order that the research question can be meaningfully applied to it.

Sampling is affected by a variety of factors, and the extent to which homogeneity of sample can be achieved (and how it is defined) is open to question. Although the sampling methodology was purposive, it should also be acknowledged that there was an element of opportunism in the way in which it was applied. Whilst the intention was to be able to select the most appropriate participants from those recruited, the difficulty in persuading men to discuss their experience meant that in practice all those meeting the criteria for the study were used.

	Age	Employment status	Ethnicity	Treatment	Sexuality	Diagnosis	In therapy	Education
Clive	34	Employed	White British	Yes	Homosexual	Yes – BN / BED	Yes	Post-graduate
Gareth	36	Employed	White British	Yes	Homosexual	Yes – BN	Yes - Beginning	Degree
Jack	20	Self-Employed	White British	Yes	Heterosexual	Yes - AN	Yes	Degree
Jo	20	Student	White British	Yes	Heterosexual	Yes - EDNOS	No	Degree
Luke	53	Employed	White British	No	Heterosexual	No	No	Secondary
Mark	19	Unemployed	White British	Yes	Homosexual	Yes – BN	No	Secondary
Michael	54	Retired	White British	Yes	Heterosexual	Yes - BN	No	Degree
Peter	42	Employed	White British	Yes	Homosexual	Yes – BN	No	Degree

Table 2.1: Participants

The sample can be considered homogeneous in that all participants were men living in the United Kingdom who (based on self-report) had at some point met the diagnostic criteria for BN. It should be acknowledged, however, that they were not drawn from a specific region of the British Isles, age-range, sexual or socio-economic group, and that they demonstrate a variety of different stages in acknowledging and coming to terms with their ED. Nevertheless, because they all met the selection criteria in the research design it is felt that the sample is sufficiently homogeneous to be meaningful.

2.5.1.2 Inclusion/exclusion criteria

The primary focus of this study was BN/BECB, but it was recognised that there is often a complex interrelationship with other eating disorders such as AN. This is reflected in the more recent trans-diagnostic approaches to treatment, such as CBT-E (Fairburn, 2008a). For this reason, participant perspectives on the role AN may or may not have had in the development of their BECB were considered to fall within the scope of this study. However, for ethical and safety considerations, it was felt important to exclude individuals with active AN. This was because it was not felt that any additional information would be gained from including such participants that could justify the risks involved. Participants were screened for active AN by establishing their body mass index (BMI), calculated using their current height and weight.

To ensure that participants met a minimum severity threshold for their BN/BECB, they were screened to ensure that at some point they had met the DSM-5 (APA, 2013) diagnostic criteria for BN. Changes to these criteria from DSM-IV (APA, 2000) mean that they may now include individuals who would previously have been categorized as having EDNOS because of a lower frequency of bingeing/purging, or because they did not satisfactorily fall within one of the subtypes in DSM-IV. This screening was also necessary because many men do not receive a diagnosis for their eating disorder, either because they do not seek help or because they are misdiagnosed when they do (Strother, Lemberg, Stanford, & Tuberville, 2012).

A particular problem with this screening was the retrospective nature of it. Although the current diagnostic criteria for BN from DSM-5 were used, it was not possible to administer a diagnostic measure such as the Eating Disorders Questionnaire because these are designed to detect current rather than historic problem eating. As this study wished to hear the experience of individuals who have recovered from BECB, as well as those actively experiencing it, it was recognised that the diagnostic criteria would need to be applied retrospectively. The resulting questionnaire contained questions framed in such a way as to indicate the likelihood of an individual having met the diagnostic criteria

for BN when their BECB was at its worst. Nevertheless, it was also recognised that such a diagnosis cannot be made retrospectively, which is why BECB is the primary term used within this study, rather than BN.

Participants were also required to meet the following additional criteria.

1. Male
2. Have met the diagnostic criteria for BN at least five years, and no more than thirty years, prior to the commencement of the study. This was to ensure participants could provide a long-term perspective on the process of BN/BECB. It ensured a higher possibility of the BN having had an opportunity to go into full or partial remission, and to facilitate recall of the original onset. Although individuals currently meeting diagnostic criteria for AN were excluded from the study, individuals with active BN were considered in-scope.
3. Aged between 18 and 65. This was to reduce risk to young and elderly adults form participation in the project.
4. Able to communicate comfortably in English. This was to facilitate communication between the researcher and participant and to reduce the possibility of power imbalance
5. Currently resident within the United Kingdom, as well as for the majority of their upbringing, and during the onset of their BN. This was to facilitate data collection and to provide a more uniquely UK perspective.

2.5.1.3 Recruitment

Consideration was given to recruitment via the NHS, subject to ethical clearance. This was discussed during interview for a placement I subsequently took up with an NHS specialist eating disorders unit. While willing to support my research, a significant problem was identified in the small number of men presenting to the service. Hence, it was felt that recruitment was more likely to be successful using targeted support groups. Additional consideration was given to recruiting from specific sporting communities

where difficulties maintaining weight are known to be associated with the development of EDs. These include boxers and horse jockeys. It was felt, however, that these communities have specific issues which would merit their own targeted studies (see section 4.3.1). More broadly, consideration was also given to recruitment via sports clubs, universities and gymnasia, should online recruitment have failed to generate sufficient participants. In practice, this did not prove necessary.

The participants taking part in this study were recruited using two support groups targeted at individuals with eating disorders:

1. Men Get Eating Disorders Too (MGEDT) - <http://mengetedstoo.co.uk/>
2. Beating Eating Disorders (B-EAT) - <http://www.b-eat.co.uk/>

Both MGEDT and B-EAT are characterised by the active involvement of former ED sufferers in a supportive capacity, as well as those currently experiencing an ED. They also support research into EDs and facilitate the recruitment of participants. Both organisations maintain databases of potential participants and make provision for researchers to advertise on their websites (B-Eat, 2015; MGEDT, 2015)

B-EAT and MGEDT were supplied with copies of the Research Proposal and the Study Advert (see Appendix B). After securing the involvement of both B-EAT and MGEDT, a modified version of the advert was placed on their websites inviting people to participate in the research (see Appendix C). This summary was also emailed by the groups to members expressing an interest in participating in research studies. All participants were offered reimbursement for agreed travel expenses and payment of an honorarium to compensate for their time participating in interviews.

Two individuals responded to the initial advert placed with MGEDT. A hiatus occurred in data collection and recruitment following the death of my daughter in February 2015, with recruitment resuming in July 2015. Following this slow initial response, an advert was also placed on Call for Participants, a website aimed at encouraging participation in scholarly research (Call for Participants, 2015). This resulted in one respondent. A further three participants were obtained through contacts made at

the 2015 MGEDT conference in Brighton, another three were the result of a targeted mailing made by MGEDT, and a final late participant responded to the advert on the MGEDT website. One participant was excluded following the preliminary interview and another following completion of the main interview. In each case this was because it was found that they did not fulfil the criteria for the study.

2.5.2 Data collection

Data collection was conducted in four phases:

1. Initial contact with participants.
2. Preliminary collection of demographic data and information relating to the onset, progression, treatment and remission (if any) of their BECB.
3. Semi-structured interview to be subjected to IPA.
4. Transcription

The original design allowed for follow-up interviews with participants should topics require additional exploration or clarification, but in practice this did not prove necessary.

2.5.2.1 Initial contact with participants

After participants had indicated their willingness to be involved in the study, and contact information exchanged, an initial approach was then made by phone or email. This was used to explain the process to each participant and to set up a preliminary data-collection interview.

2.5.2.2 Preliminary data collection

Following the recommendations of Reindl (2001), standardized measures were used for Phase 1 taking the form of a questionnaire administered in advance of the main interview (See Appendix D). The research design allowed for this to be conducted by post, the participants being asked to return the form in a pre-paid envelope. However, it gave preference to the completion of the form by the researcher during a preliminary telephone interview. This was to ensure completeness of the information gathering and

to avoid the need for a subsequent clarificatory telephone interview. In practice, all participants were happy to participate in preliminary telephone interviews and none of the forms were completed by post and follow-up interview.

Prior to the commencement of each telephone interview, the participant was given a full briefing based on the contents of the Study Information Sheet (see Appendix E). This emphasised the following points:

- The purpose of the study
- That participation was voluntary
- What participation would involve
- Risks
- Advantages and disadvantages
- Confidentiality
- Right to withdraw

2.5.2.3 Main interview

A semi-structured approach permitted the interview to be adapted to the needs and interests of the participant, as well as allowing it to pursue fruitful emerging lines of inquiry (Smith & Osborn, 2008). Interviews were conducted in venues chosen in consultation with the participant. Three took place in the participants' homes, one in their place of study, one in their place of work, one in a hotel and three at City University. Key criteria in selecting venues were

- Comfort and safety of the participant and researcher
- Convenience for the participant
- Privacy/lack of likelihood of interruption

Before commencement of the interview, participants were reminded of expectations and confidentiality. They were given an opportunity to ask questions about the purpose and process of the interview, and asked to sign a consent form (See Appendix F). Once the interview commenced, participants were engaged in conversation

in order to build rapport and make them feel at ease. This took the form of ice-breaking questions building upon the information derived from the initial telephone contact. The interviews then proceeded using the semi-structured schedule shown in Appendix A. Care was taken to adapt these questions in response to the participants' previous answers and interests. On completion of the interviews, participants were supplied with a debriefing sheet (see Appendix G) and given an opportunity to ask questions about the process and discuss any concerns arising.

All face-to-face interviews were recorded with the consent of participants. The recordings were made using an Olympus DS-3500 digital voice recorder with real-time encryption and PIN protection. A back-up recorder (an Olympus DM-5) was also used in case of failure of the other recording equipment. On completion, the recorders were checked to ensure that they had captured the interview successfully. The recordings were then downloaded from both devices onto a laptop running Windows 8.1 Pro with BitLocker disk encryption. Recordings were retained on the encrypted recorder but deleted from the unencrypted one. Each recording was named using the participant number and the date of the recording. The hard disk was regularly synchronised with a removable encrypted memory stick which was kept in a locked cabinet offsite to ensure data security.

2.5.2.4 Post-interview reflections

Following each interview, I recorded my reflections on the process. This enabled me to capture my thoughts and covered aspects such as

- Impressions of the interviewee
- Interviewee behaviour
- My own feelings and behaviour
- Body language
- Engagement
- Eye contact

- Use of language
- Emotions demonstrated
- Emotions elicited within me
- Thoughts about emergent themes

An example of a post-interview memo can be found in Appendix H.

2.5.2.5 Transcription

Transcription was considered an important part of the analytic process, providing as it did the first opportunity to reflect on the content of each interview. For this reason, all transcription was conducted by the researcher as soon as practicably possible following the completion of each interview. Recordings were played back using Express Scribe software controlled with an Alto Edge foot pedal to assist in hands-free pausing and rewinding. On completion of each transcript, the recording was played once more while reading the text to correct any errors.

The transcription methodology drew from the principles laid down by Smith, Flowers and Larkin (2009), placing the emphasis on content rather than prosodic aspects. All transcriptions were made in landscape format using Microsoft Word, the following conventions being used:

- All lines numbered for ease of reference
- Short pauses identified by four dots:
- Long pauses identified in squared brackets, along with other information clarifying what was taking place at that point in the interview, such as interruptions, coughing fits, laughter etc.

The questions listed in the interview schedule were inserted into the transcripts to enable ease of navigation. These were clearly distinguished from the actual transcripts by using their question number and colouring them in blue.

The resulting files were named using the client number and interview date. Throughout the transcription process a notebook was kept to hand to jot down any initial

thoughts and observations occurring during the process. analysis, each transcript was edited to assign pseudonyms and remove identifying features. These edited transcripts were renamed to include the participant pseudonym to ease identification. An example of an initial, pre-analysis transcription can be seen in Appendix I.

2.5.2.6 Piloting

One participant, a 53-year-old man, was selected for a pilot interview in order to test the processes and the semi-structured interview schedule. The outcome of this demonstrated the robustness of the interview schedule and it was not felt necessary to make any alterations to it for subsequent interviews. The quality of the data obtained in the pilot led to its inclusion in the study, although lessons were learned in terms of phrasing and pacing for subsequent interviews.

2.5.3 Data analysis

Data analysis followed the process proposed by Smith et al. (2009):

1. Reading and re-reading
2. Initial noting
3. Developing emerging themes
4. Connecting themes

Although Smith et al. recommend a paper-based approach, the methodology also allows for the use of analytical software. Initial coding took place using the comments feature of Microsoft Word. Transcripts were subsequently imported into NVivo, a software package designed specifically for qualitative research.

2.5.3.1 Reading and re-reading

Before coding, each transcript was read and re-read to familiarise myself with the text. Pietkiewicz and Smith (2012) have emphasised the importance of immersing oneself in the data, a practice that applies equally to other qualitative methodologies (Langdrige, 2007; Willig, 2008). Initially this process also involved listening to the

recordings of the interviews and provided an opportunity to check the accuracy of the transcriptions. Notes were also made on the transcripts and in my research journal of anything that struck me, including possible themes and personal resonance. In this way, as described by Smith et al. (2009), there was a natural blurring between the initial phase of reading and re-reading, and the initial noting.

2.5.3.2 Initial noting

Following the methodology proposed by Smith et al. (2009), three types of comments were used in this phase of the analysis:

1. Descriptive comments
2. Linguistic comments
3. Conceptual comments

Using the comments feature of MS Word, descriptive comments were made using ordinary text, linguistic using italics and conceptual using underlining. Descriptive comments were used to highlight the content of what the participant was saying, linguistic comments to focus on their specific use of language, and conceptual comments to engage with the content on a more in-depth basis, allowing for the subsequent identification of emerging themes. In many instances, these took the form of questions rather than observations. An example of initial noting can be seen in Appendix J.

2.5.3.3 Developing emerging themes

The next stage in the analysis involved coding content and themes in a more systematic manner. This involved transferring the transcripts into NVivo. A divergence from the process recommended by Smith et al. (2009) was that I coded at a high level of intensity, initially increasing rather than reducing the level of detail. This had a subsequent impact on the process of abstraction, slowing the process of identifying emergent themes. Nevertheless, the fine granularity of the coding made subsequent recoding to broader, more conceptual themes, relatively easy to achieve.

Emergent themes were identified by observing common threads in the coding and accompanying comments. Where it was felt that coding had been achieved at too fine a level of granularity, codes were grouped together to form thematic hierarchies within NVivo. Examples of emergent themes can be seen in Appendix K. Throughout this process I continued to add reflexive comments using the notes facility within the software and my research journal.

2.5.3.4 Connecting themes

Smith et al. (2009) encourage innovation in the analysis process, and instead of adopting a paper-based approach to connecting themes, I instead used NVivo to achieve this by further developing hierarchies as a means of exploring relationships between themes and creating these connections. The emergent themes were then listed and grouped into clusters of superordinate and subordinate themes (see L). These were, in turn, checked back against the transcript to ensure that they remained valid.

The output from this process was a table of themes for the first participant. Scope notes were written for each theme to ensure that their meaning and breadth of application remained fully understood. Any subsequent alterations to scope notes required previous use of these themes to be checked to ensure that they remained valid to the marked-up texts.

2.5.3.5 Moving to the next case

The four initial steps in this process were repeated for each transcript in order to “bracket” them and allow each to be considered on its own merit. This is part of the idiographic process of IPA, attempting to avoid as much as possible the contamination of the analytic process of each transcript by the knowledge gained through the analysis of the preceding ones (Smith, Flowers, & Larkin, 2009). Each transcript was processed in turn following these steps until this stage of the analysis was completed. Because I was using software which embedded a developing ontology, I often found when

identifying an emerging theme that the same theme had already occurred in an earlier transcript. I was careful, however to be driven by the transcript rather than the ontology.

2.5.4 Looking for patterns across cases

Once steps one to four of the analytic process were complete, I was able to compare the theme clusters across all transcripts. Because each transcript had been analysed independently of the others, I examined the ontology developed within NVivo looking for duplication of concepts. Where these were found they were merged to ensure common coding across all transcripts. Because NVivo allowed me to analyse transcripts simultaneously as well as individually, I was able to examine how themes occurred across transcripts and could easily apply new superordinate themes. This allowed me to develop the master themes within in Vivo, dynamically linked to the instances of those themes occurring within the transcripts themselves (see Appendix M).

2.6 Ethical considerations

This study was approved by City, University of London's Psychology Department Research Ethics Committee (see Appendix N). It was designed and conducted in accordance with the following guidelines:

- *Framework for Good Practice in Research* (City University London, 2010).
- *Code of Ethics* (BPS, 2009).
- *Code of Human Research Ethics* (BPS, 2010).
- Good Practice Guidelines for the Conduct of Psychological Research within the NHS (BPS, 2010).
- Standards of conduct, performance and ethics (HCPC, 2012).

In particular, it was guided by the following ethical considerations (after Willig, 2008):

1. **Informed consent** – The purpose of the study, and the procedures involved, were fully explained to all participants at the recruitment phase – there was neither necessity nor justification for any deception to take place. Participants

were sent copies of consent forms prior to interview, along with a copy of the Participant Questionnaire, and asked to sign it prior to preliminary data collection. Where this was done by telephone, participants were asked to give verbal consent. They were then asked to return the consent form in the prepaid envelope provided, or to bring it with them to the main interview should they be selected for participation. In the event of no form being received, participants were asked to sign a consent form prior to the main interview taking place. Participant questionnaires completed for individuals not subsequently participating in the main interviews were destroyed.

2. **Right to withdraw** - Participants were informed of their right to withdraw at any point up to submission/publication of the results of the study. It was explained to them that no explanation would be necessary, and no penalty imposed.
3. **Confidentiality** – Conditional confidentiality was maintained towards client material throughout the research process. All names and identifying features were removed from transcripts, although it was explained to participants that there remained a possibility that they could still be identified by those who were very familiar with them and their circumstances. It was, however, made clear that in the event of information being disclosed concerning criminal activity, or harm to self or others, this could require disclosure to others.
4. **Duty of care** – Participants were made aware of sources of support should they become unexpectedly distressed as a result of taking part in the research. They were told that interviews would be terminated if necessary and initial support provided through debriefing.
5. **Debriefing** – Participants were given an opportunity to ask further questions and discuss any feelings of distress arising from the interview process. They were kept informed of changes, both to the process or purpose of the study, and given access to the outcomes. This information was contained in a debriefing sheet given to all participants (see Appendix G).

2.7 Reflexivity

Willig draws attention to the differences in emphasis on reflexivity exhibited in qualitative research. She also draws a distinction between personal reflexivity and epistemological reflexivity. The former focusses on the ways in which the research has been shaped by our own values, interests, beliefs, experiences etc. It also takes account of the ways in which we have been changed through participation in this research process. The latter requires us to consider our ontological and epistemological stance in relation to the research question, and to continue this reflection throughout the research process (Willig, 2008b). These aspects of reflexivity are addressed in sections 4.5 and 4.6. This section, however, will focus on personal reflexivity with respect to the study.

We have seen that the principle of double hermeneutics acknowledges the role of the researcher as an integral part of the research process. It is for this reason that reflexivity assumes a greater level of importance (Howitt & Cramer, 2008). Reflexivity also plays a key role in the practice of counselling psychology and is vital in understanding the part that transference and counter-transference may be playing within therapeutic sessions (Woolfe, Strawbridge, Douglas, & Dryden, 2010). As both a practitioner and researcher I have been trained to develop self-awareness to ensure that I work ethically and adopt an evidence-based approach. While Langdrige acknowledges that it is inevitable that the researcher's preconceptions, prior knowledge and approach will contaminate data, this does not hinder the pursuit of knowledge if such contamination is made explicit (Langdrige, 2007).

Langdrige has developed a list of questions which I have used to inform my reflective process (Langdrige, 2007). These included:

1. Why am I undertaking this research?
2. What do I hope to achieve by it?
3. What is my relationship to the subject?
4. How might I influence the research?

A key element of this is my relationship to the subject matter. My eldest daughter suffered from BN/BECB, and this provided a particular incentive for the study of this condition and its progression. This means that I inevitably brought my own experiences and perspectives to the research question. That I might also be adversely affected by my involvement in the study was something that I needed to remain aware of. This assumed an unanticipated level of importance following her death which occurred during the data-collection phase of the project.

In terms of my own influence on the research, the following considerations (among others) applied and required particular vigilance:

1. I had a vested interest in believing that recovery from BN is possible.
2. I needed to guard against resistance to what is reported in terms of attitudes/behaviours of friends and/or relatives as contributory factors in the onset of BN (or inhibiting factors in recovery), particularly if I recognised such attitudes/behaviours in myself.
3. My increasing personal understanding of BN had the potential to influence the way in which I conducted interviews as the project progressed.
4. As a trainee counselling psychologist, I could have been predisposed to find evidence for the efficacy of psychological interventions in the recovery process and to phrase my questions accordingly.

In the same way that participants may have found themselves adversely affected by the research process, there was a similar danger for myself as the investigator. In hindsight, I can now see that the bulk of the interviews conducted after my daughter's death were probably carried out while I was in a state of shock, as was my coding and analysis. It was during the writing of the Analysis chapter that I experienced most distress, and I addressed these issues through personal therapy and the use of a reflexive journal. I also discussed with my supervisor how to integrate this experience into the text of this thesis.

2.8 Quality and validity

In order to address issues of quality and validity, the following core principles were adhered to wherever possible (Yardley, 2000):

- Sensitivity to context
- Commitment and rigour
- Transparency and coherence
- Impact and importance

In addition, efforts were made to improve quality through the trialling and prototyping of research materials. All research outputs were carefully documented and stored to ensure a proper paper trail to facilitate external verification (Smith, 2008).

Chapter 3: Analysis

3

3.1 Overview

The analysis of the transcripts confirmed their richness, and the content was addressable from a wide variety of different angles. It was important, therefore, to focus on the key research question of male lived-experience of BECB. Four aspects of the content emerged as worthy of particular attention: Experiences of parenting and their contribution to ED development, experiences of gender and identity, the need for, and loss of, power and control, and experiences of help seeking. These were embodied in the superordinate themes and subthemes shown in Table 3.1.

Themes and Subthemes	Description
1: “Really? We’re going to do some Freudian shit?”	Painful parenting experiences and their contribution to ED development
1a: “They fuck you up, your mum and dad” (Larkin, 1971) 1b: “I learnt that I wasn’t going to get much from them” 1c: “I think she was projecting her own stuff onto me”	Parental fear and control Deprivation and neglect by parents Family issues with food and body image
2: “I am a man”	Gendered bodies and identity
2a: “So imagine if you are a bloke” 2b: “I wish I had a better body”	What does it mean to be male? How men experience their bodies and bodily change in childhood and early adulthood
3: “It’s a control....that’s out of control”	The need for, and loss of, personal power and control
3a: “I wanted to be visible.” 3b: “This [...] shame of a man” 3c: “It was my secret [...] power over everybody” 3d: “I...managed to control it [...] but it ended up controlling me”	Being invisible Loss of emotional control Exerting control Control of the ED
4: “You’re a shy bloke and you’ve got Bulimia. So where the hell do you go?”	Experiences of help seeking
4a: “We don’t normally...speak to men” 4b: “I was lucky. She had had a lot of experience”	Men as other Therapy fit for men

Table 3.1 Superordinate themes and subthemes

The first superordinate theme examines male participants' experiences of parenting, and its contribution to the development of their EDs. This is exhibited in parental fear and control, disengagement, and the impact of parents' own attitudes to food and body image. The second superordinate theme focusses on male experiences of gender and identity, and how these contributed to their ED development. In particular, the subordinate themes look at what it means to be male, and the impact of male bodily change in adolescence and early adulthood. The third superordinate theme looks at the need for, and loss of, personal control. This includes feelings of invisibility, loss of emotional control, exerting control over others, and issues of control in relation to the ED itself. The final superordinate theme looks at experiences of help seeking. This focusses on men as "other" (not fitting in with society or the treatment model), and treatment fit for men.

It should be noted that the content examined within these themes and subthemes, frequently overlaps. An example of this can be seen in subthemes 2a and 2b where it is difficult to separate male identity from its physical manifestation. This is an inevitable consequence of the subject matter, and effort has been made to avoid excessive overlap by providing cross-references to avoid unnecessary duplication.

3.2 Superordinate Theme 1: "Really? We're going to do some Freudian shit?" – Painful parenting experiences and their contribution to ED development.

Recalling a session when asked by his therapist to talk about his parents, Jack remembers thinking,

"Really? We're gonna do some Freudian shit? Let's just move on" (Jack, 637).

Problematic familial relationships feature prominently in the narratives of all but one of the participants in this study, although it is often only through therapy that they have come to understand this fully. Theme 1 focusses on participant experiences of painful

family relationships, concentrating on three sub themes covering fear and control, deprivation and neglect, and family issues relating to food and body image.

3.2.1 Subtheme 1a: “They fuck you up, your mum and dad” (Larkin, 1971) – Parental fear and control.

Many participants appear to have experienced control exerted over them by their parents in childhood (and beyond), including strictness, emotional manipulation and violence. Subtheme 1a explores this parental control, the fear and anger it induced in participants, and the impact it had (and sometimes continues to have) on them.

Jack’s therapy has caused him to re-examine aspects of his relationship with his mother and father. He has come to recognise his parents’ use of emotional control through guilt:

Jack: [] she really played the guilt card, a hell of a lot. She didn’t mean to [] when I was like...six or seven I really didn’t wanna wear a specific jumper, and she said, “You’ve ruined this holiday”, and she went...out. Stormed off crying...erm...and then my Dad was there and like, “Why do you always do this, [Jack]?” And I’m like, “Well I didn’t.... I just didn’t want to wear a fucking jumper”.... (Jack, 283-289)

Jack is an entertainer and he tells this story for comic effect: as a six or seven-year-old, it seems unlikely that he used the word “fucking”. The comedy also serves as a cover to mask his true feelings: at a superficial level there is little sense of the hurt and vulnerability that he experienced. Nevertheless, there is an authenticity to his narrative and, at a deeper level, a sense of grievance comes through, particularly towards his father. His mother provokes feelings of guilt through her overreaction (also played for comic effect), but Jack asserts that this is an unconscious act on her part: (“she didn’t mean to”). His protectiveness towards his mother contrasts with his recollection of his father’s blaming of him for his mother’s distress. There are interesting juxtapositions, with the adult perspective conveyed through his swearing, the vulnerability of a child trying to assert his wishes, and the child’s perspective of his parents’ own behaviours. There is a sense that even at the time he felt these were unreasonable. Most of all, there appears

to be a lack of empathy on the part of Jack's parents, with little attempt to understand his wants and needs.

Clive also cares about his parents and demonstrates a similar need to contextualise their behaviour towards him. Nevertheless, like Jack he does not experience empathy from them, particularly in terms of his body dissatisfaction:

Clive: *And my dad used to berate me for spending so much time...trying to improve my appearance...to the point where I made the conscious decision once I was about thirteen that I used to get up a good forty-five minutes, half an hour before everybody else on a morning, because I just couldn't stand dad going on about...you know. I wanted to try using gel in my hair. And he just laughed at me for that. And, so then I felt humiliated, so then.... You know. And all the lads were wearing gel in their hair.... (Clive, 1101-1106)*

Clive appears to be driven by a desire to fit in with his peers by emulating their use of gel. Ironically, this causes him to stand out at home, eliciting his father's attention and ridicule, resulting in strong negative emotions for Clive, experienced internally as humiliation. His resulting anxiety leads him to go to great lengths to avoid being mocked by his father.

Clive goes on to talk about his mother's insistence on individualism:

Clive: *I didn't particularly want to conform. I was always insistent I had my own natty little style [] And [] Mum utterly hated the sheep thing, you know. Looking like everyone else, dressing like everyone else. She hated that. And that was deeply instilled: You should never grow up to be a sheep. [] You shouldn't be just following the crowd.... (Clive, 1142-1146)*

Clive appears to own his individualism ("I was always insistent"), but it seems that this contrasts with his mother's own insistence on individuality which he describes as "deeply instilled". What comes across is a sense that Clive's only choice was *how* rather than *whether* he developed his own sense of identity. The resulting tensions in his relationships with family and peers are obvious: his mother has emphasised his need not to conform, but he wants to fit in with his peers, or at least stand out on his own terms. However, when he attempts to fit in with his peers, it draws attention to himself within his family.

His parent's lack of empathy extends to their obliviousness to his fear:

Clive: *I think what really got me on the path of any sort of disordered behaviour was just the fact that [] I lived in fear constantly, and mum and dad didn't get that at all. [] They thought my life was a breeze.... And they reminded of that...constantly. [half laughing] Which they do now, to be fair. []because I'd...I was...terrified of the paper round [] I had to do, because going into strangers' gardens and encountering....dogs and gangs of kids [] just...really scared me. (Clive, 769-780)*

Because of the importance his parents placed on self-reliance, Clive was expected to earn pocket money by undertaking jobs such as his paper round, something that he “had to do”. He cites his fear as the major contributing factor in the development of his ED but his parents’ lack of appreciation of this extends to this day. This fear of being bullied explains his desire to fit in with his peers by looking as normal as possible, hence the reason why he took care over his appearance in the mornings. This conformity appears to be about reducing visibility (in the same way that he reduces his visibility to his father in the mornings), but the paper round makes this visibility high, exposing him to a variety of anxiety-inducing threats.

Michael also talks of the anxiety caused by his mother, but his account is less sympathetic than those of Jack and Clive:

Michael: *Every night we had to tell her how many million, billion gazillion, erm, google....googolian or....bags of sugar we loved her.... Erm, and erm, it was a, a contest between the, the, the three kids to, to come up with the highest, erm, number possible. [] I suppose....the anxiety was pleasing her. (Michael, 563-572)*

Michael uses the word “sugar”, but there is a sickly, saccharine-sweetness in the language of this excerpt. “Had to” suggests a sense of coercion, and that this was an unwilling competition. Moreover, I sense that the real competition was not with his siblings but with his mother. In the context of his mother, winning is very important to Michael. By inventing a number that represents more than infinity, Michael is ensuring that he cannot be beaten.

For Gareth, being beaten takes on a more sinister meaning when speaking of his parents:

Gareth: *[] my mother was much more... verbally... disciplinarian [] But when we were very small [] there was [] a stick...that was kept in the litter bin...er... waste-paper basket [] which he used more on my brother*

than me. [] But he'd, kind of beat us with a.... kind of...s...stick like that.... Up until.... I remember my mum saying that they weren't going to use it any more...erm...because [] [half laughs] my brother was getting too old. I'm guessing I would have been [] well probably about six? (Gareth, 323-333)

Gareth paints a vivid picture of corporal punishment during his early years, and there is a sense that he was equally in fear of his mother's verbal discipline. Although Gareth laughs, there is a contrast with the slight stammer when he recalls his father's use of the stick. These are significant memories that serve to create an image of a strict family environment lacking in intimacy between child and parents. The continuing presence of the stick in the waste-paper basket establishes a sense of oppression to which there is no balance elsewhere in Gareth's narrative.

Jo also appears to have grown up in an oppressive environment, having a violent and abusive father:

Jo: Ahm, but throughout my childhood he was also....ah...a raging alcoholic and very physically and mentally abusive to my mother and to the children. [] My childhood was spent half in fear of him and half constantly being compared to him.... And it was just people saying, "Oh, you're a daddy's boy"....[] ...in the end I wanted...to...lose weight and not end up being like him. (Jo, 421-429)

His father's violence and alcoholism cause Jo to resent comparisons with him, particularly those based on a physical resemblance. The phrase "daddy's boy" suggests an assumption that he would regard such comparisons as a compliment, whereas the truth appears to have been clearer to his mother who used this as a form of censure. What is particularly interesting here is the remove that Jo appears to adopt towards his family. His contempt for his father and desire to avoid being compared with him clearly inspired his desire to lose weight, but it is his use of the phrase "the children" rather than "my siblings" that is particularly telling. This is not due to antipathy: rather it seems that Jo is trying to locate himself outside of his family as a means of avoiding these comparisons.

3.2.2 Subtheme 1b: “I learnt that I wasn’t going to get much from them” – Deprivation and neglect by parents.

As well as the lack of empathy and fear experienced by participants, a spectrum of dis-engagement is also present in their narratives, ranging from parents “not getting” their children (not giving them the time and attention they wanted/needed) through to parental emotional withdrawal and, in one instance, abandonment. Sometimes the disengagement is on the part of the participants, resulting from not having their needs met, but more often it is by the parents. There is an overarching sense of a lack of visibility of many of the participants to their parents. This subtheme explores the degrees of disengagement experienced, and its consequences.

Gareth speaks of his own disengagement from his parents in terms of an emotional response to their past failure to meet his needs:

Gareth: *I think it was [] some sort of loneliness, really, I was feeling. [] I'd never, kind of felt like I could really [] confide in my parents. [] And I don't know, you know, whether that's 'cause I.... learnt that I wasn't going to get much from them or [], you know, when I'd tried before.... I can't think of examples, but.... And... yeah. And just being quite, [] sort of solitary and [] and as I say, quite, sort of, generally quite sort of secretive, really. (Gareth, 244-256)*

His narrative portrays a lack of, rather than a negative, response from his parents when attempting to confide in them. There appears to be unfulfilled need in this passage, with its emphasis on solitariness and loneliness (a word that features often in Gareth's narrative). He also speaks of secretiveness, which in turn is likely to compound the isolation and lack of opportunity to talk through difficult thoughts and feelings.

Elsewhere Gareth describes his father's emotional detachment (see Section 3.2.3) and goes on to speak of periods of withdrawal by him:

Gareth: *And he..he used to go through these, sort of, periods of again, what I later thought of as depressions [] and I can remember those being quite significant [] when I was a kid. Where, all of a sudden he would stop...stop talking to us all...inc....including my mum. [] And that would last for, dunno. A week? Maybe ten days? [] Just nothing. And we'd kinda know not to....say anything to him. [] Erm, I can't remember even trying [] to be honest.... I can remember, sort of, between me and my brother, and my mum, it would be almost joked about that we'd better leave him alone. (Gareth, 262-277)*

Although not physically absent, his father might as well have not been there, and again we can see the parental disengagement reciprocated by the child. There is an interesting contrast in Gareth's language. On the one hand he talks of it being "joked about" whilst elsewhere describing these incidents as "significant"; one moment trivialised and the next imbued with great importance. The impact on Gareth and his relationship with his father is clear. As well as not trying to communicate with him in these periods, there is little sense elsewhere of a close relationship with his father. Like many of the participants, Gareth appears to lack a male role-model to encourage openness of expression. The repeated pattern seems to be avoidance of discussion when it comes to difficult thoughts and feelings.

In contrast to Gareth, Clive's parents did pay attention, but not to the things that mattered most to him. Instead, the emphasis seems to have been on earning money and completing family chores rather than concentrating on homework and continuing education:

Clive: I had a paper round [] And then that turned into a Saturday and evening job when I was at sixth form college. And then as soon as I came to university...erm...my dad refused to kind of help me out with money. I had to earn it. Erm... So in some ways they really wanted us to grow up. You know. Dad was upset when I wanted to carry on studying. He thought I should do my.... statutory exams and then leave and, you know, get a job and then leave home. (Clive, 626-631)

Clive is factual in his description of his father's response to his request for support, and there is a compassion for them in this passage, attributing it to a desire to prepare them ("they really wanted us to grow up"). It conveys a sense of tough love, but there is also a gulf between their aspirations and values which comes across as alienating, as if Clive and his father are living in different worlds. This desire to want Clive and his brother to "grow up" is in direct contrast to his fear of doing so, something that seems to have been a contributing factor in the development of his ED.

As well as lack of engagement, there are instances of parental absence in the narratives. Clive remembers spending a night alone in hospital when he was eight-years old:

Clive: *When I was in...primary five [] I had to go into hospital overnight. There was a problem with my ears. I was partially deaf in one ear [] and erm....and they gave mum the option ...or one of my parents the option of staying...overnight with me, 'cause I was only eight [] and [laughing] they didn't! They left me there.... I cried all night. It was horrible. But they, you know, anything that was character building [laughing] , that was a good idea in dad's book. [] So things like that, they [] were all about, you know, "you have to learn to be independent". "You [] have to learn to be self-sufficient". "You have to look after yourself".... (Clive, 677-686)*

Although he is laughing when describing his parents not choosing to stay with him, there is also incredulity, and he is quite explicit about the effect it had on him. The narrative conveys a child's need and the parents' lack of response to it (he "cried all night"), and this incident remains in his memory. Clive attributes his parents' lack of response to wanting him to be independent and self-sufficient. Nevertheless, I sense that this independence was expected to be acquired through hard experience rather than being taught. Echoing his parents' language ("you have to learn to be independent"), Clive draws attention to the contrasts between his implied sense of how a young child should be cared for and the care he actually received.

Michael encounters lack of engagement in a different manner: for him it is a disengagement occurring when his sister is born:

Michael: *....they were married for eleven years before I was born....erm....and I've always been told.... "We..we..we.... I wanted you so much....We waited all this time for you and you...." Erm.... Frankly I didn't give a shit, really! [laughing] [] But, then I think.... I was....erm....metaphorically dropped....erm.... New baby comes along. New play thing.... Erm, and lose interest in me.*

Michael has been told (repeatedly) how much he was wanted. I think he wanted me to feel the pressure and emotional manipulation contained in this. That he "didn't give a shit" seems due to him no longer believing it to be true, as if even as a child he was aware of this manipulation. He implies that his mother saw his sister as a new toy, thereby dehumanising her (and, by extension, Michael). His choice of words also has the interesting effect of reversing their roles by infantilising his mother. I couldn't help wondering about the significance of the gender of the two children. Was a girl of more interest to his mother than a boy?

As a child, Michael found himself responsible for the care of his younger siblings, sometimes with potentially lethal consequences. In one episode, he was sent to his room for being naughty, leaving his brother and sister (who he was expected to be looking after) alone. Unsupervised, his brother took an overdose of aspirin, thinking they were sweets:

Michael:and so..because I wasn't looking after them....and he'd taken the tablets, it was my fault.... So I guess I would have been about, what, five? Six? Something like that at the time [] Well.... 'Ang on.... Why.... And I've talked...talked through some of these things before, which is why I can be a bit more rational about them. [] First of all, how can it be my fault if I'm out the way, and why the hell as a five or six-year-old am I supervising two younger children? (Michael, 364-372)

Michael says that he has talked through these things before (I sense in therapy) but the anger and frustration is palpable, even though the events took place nearly fifty years ago. There is strong injustice felt in being held accountable for something that took place in his absence. He uses child-like language (“naughty boy”, “sweeties” etc.), as if Michael has internalised the voice of his mother, and it is that voice that he sometimes adopts when describing feelings of powerlessness. He is also condemnatory of his mother for using (and in this case, not using) a six-year-old to supervise her children. Here we see the adult Michael reassert himself (“why the hell”). Michael does not explicitly link this behaviour to the development of his ED, but it is a powerful part of his narrative, and although there appear to be other motives behind his overeating (see Section 3.2.3), I also wondered whether it fulfilled a self-soothing purpose.

In contrast to Michael's experience of his mother's absence, expressed through her lack of engagement with her children, for Mark his mother's absence is literal:

Mark: My mum's not around, so that's one thing. [] From about two. [] Sort of left about that sort of age. Then she sort of came back a bit, like when we was like ten, eleven. Erm, and then she sort of vanished again when I was about thirteen? [] So she sort of dabbled here and there. She sort of appeared and then she left, and it's sort of her pattern. [] She's done it again recently. She appeared, like, for a few years in the last few years and then she's gone again []. So I don't think much of it now, but back then it probably affected me a lot. (Mark, 313-325)

Despite saying that it is something he no longer thinks about, this is Mark's primary response to the question of how he accounts for the development of his ED. His description of his mother's parenting is remarkably flat and devoid of description. She "appeared", "is gone" or "vanished", contributing to an illusory, insubstantial feeling about her. Mark's mother has been away for most of his childhood, but he has little to say about the times when she did feature in his life. His use of the word "dabbled" conveys a lack of belief in her serious intent. He also speaks in terms of a "pattern", as if her absence is the one aspect of her behaviour that is dependable.

3.2.3 Subtheme 1c: "I think she was projecting her own stuff onto me" – Family issues with food and body image.

A number of participants have discussed their parents' own issues with body-image and/or food. This subtheme examines these and the influence they appear to have had on them as they were growing up. This inevitably introduces control for the first time (something that will be explored further in Section 3.4), as the parents' own struggle for control over food is projected onto their children, consciously or unconsciously.

Mark's meals were prepared by his father, and plated in the kitchen before being served to him. This meant that he had no control over portion sizes:

Mark: Meals used to be quite....heavy. Quite excessive. Erm...like a lot of food. So that would definitely lead into it. Erm. Because I was overweight...throughout a lot of childhood. [] Like adult-size portions, so [] for example, maybe, double what anyone...that was a child would expect...to have. Or that you'd expect a child to have...you know...maybe double that. (Mark, 338-348)

Mark emphasises the quantity of food through repetition ("double"). He uses the phrase "adult-size" to demonstrate the inappropriateness of it, and links it with being overweight as a child. Mark shows compassion for his father, however, seeking to excuse him:

Mark: I think maybe if my dad would have had more money he'd have made a few better choices [] in the things he brought back....and...'cause there's not a lot of jobs going around here. [] And also sometimes I've thought that maybe my dad just didn't know, because he sometimes says, "Oh. I...I didn't know". Maybe it was sort of ignorance to what a healthy diet is.... That could be another factor. (Mark, 396-409)

He portrays his father as a victim of circumstance, bringing up a child on his own in an area of high unemployment, as well as lacking the knowledge to feed his son more healthily. Although there is no overt resentment in his narrative, his direct quoting of his father (“I didn’t know”) suggests that this is something that they have discussed in the past, and Mark is clear that this was a contributing factor in the development of his ED.

Unlike Mark, Gareth is fed by his mother who was overweight, and appears to have had her own issues with food. Although she does not seem to have used food itself as a means of control, it clearly resonates strongly with her when he tells her that he wants to go on a diet:

***Gareth:** And she wasn't really having any of that... And.... She also, you know, used to make, you know. I think she was projecting her own stuff onto me. She was just ma..mak.... You know, sometimes made hurtful comments about my size. [] You know. And, erm.... So I think that's..that's a very important part of where this is come from. (Gareth, 161-166)*

On the one hand, Gareth’s mother reacts negatively to his wish to diet, but on the other she is critical of him for being overweight. This places him in a disempowering, no-win situation. He shows empathy for her by speculating that her behaviour was driven by her own body-image anxieties, but this is immediately followed by the recollection of her critical comments. This clearly had a profound impact on him, again citing it as a key contributing factor to the development of his ED.

Clive was also unable to manage his own portion size, but food was additionally used by his parents as a form of emotional control:

***Clive:** Food was really important. We all had to sit down...together at the table. [] Er...we had to eat everything. [] So it didn't matter how much of it...or whether you liked it or not....[]we had to eat everything. Erm... And you couldn't get down from the table until you did. [] And it was seen as, you know....really naughty and extraordinarily disrespectful to...to not eat stuff that mum had cooked. (Clive, 379-387)*

Like Mark, Clive uses repetition to emphasise the need to clear his plate. This is presented as a rule of behaviour (“we had to”) with the sanction of being kept at the table if it was not obeyed. That not finishing his mother’s food was seen as “naughty” and “extraordinarily disrespectful”, introduces an element of emotional blackmail. I sense a

confusion between food and love in this passage, with food seen as a demonstration of love within the family and failure to eat it interpreted as a rejection of it.

Like Mark, Clive's food is plated before being served, something he describes as a working-class characteristic before going on to say:

Clive: I was given kind of dad-sized portions from being [] really quite young. [] And then made to eat it all...and... But we also had lots of embargoes on food. So that you could eat certain foods but you could only eat them on certain days. Which was a Friday, the end of the week. That was like a treat day. [] It was used as a reward, but it was also heavily sanctioned if you...if you didn't...do what you should do. (Clive, 739-748)

As with Mark, Clive's servings are abnormally large. The phrase "dad-sized portions" compares with "adult-sized" (although more connected with his father) and suggests being inadvertently encouraged to overeat. The lack of choice is underlined by the phrase "made to eat it all". Clive is not in control of his food, and this extends to the "embargoes" placed upon it. This word suggests a laying down of the law: rules by which Clive and his siblings must abide. These seem to be linked to his parents use of food as a form of reward and punishment, with sanctions being imposed for non-compliance.

Michael also experienced food as a means of coercion and control, again linked with love:

Michael: From a fairly early age I can remember food being actually both....erm....well, the stereotypical carrot and stick....erm....and even to the extent of my wife.... Before she was my wife....girlfriend....coming home with me [] and being required by my mother to eat her cabbage....which, it....it sounds ridiculous, when....when you think about it. But we would have battles with my sister....sitting there, refusing to eat cabbage, erm....but I was a good boy because I ate all my food....(Michael, 10-15)

Like Clive's parents, Michael's mother demands that her children (and their guests) demonstrate their love by consuming her food. Michael's use of the word "battle" adds to his portrayal of food being weaponised. For his sister, it represents a means of rebellion, but for Michael it is an opportunity to appease and obtain his mother's approval (and love?). It is also a means for his love (and obedience?) to be tested by his mother. The infantilising is evident in Michael's language. He is a "good boy" for eating his food,

but ironically a “naughty boy” when, in consequence, he becomes overweight: a confusing situation for a child to be in. Throughout his narrative, Michael emphasises his compliance as a child and adolescent. It is only as an adult that he appears to have asserted himself and obtained some freedom from his mother’s control and influence.

Elsewhere, Michael talks about his parents’ own disordered eating:

Michael: *I mean, food has always been..an issue, and... because Mother was always concerned about her weight. I’m..I’m convinced...that my dad had an eating disorder [] erm....because he used to talk about food being, getting stuck in his throat, and we would hear him, erm.... The term he used was, was, was “heaving”, but basically being sick. [] Erm.... And, erm, he was always quite thin, and, erm, he had...his teeth were bad. (Michael, 458-464)*

He mentions his mother’s weight concerns, but provides positive evidence of his father having had an ED, probably BN from his description of his father’s vomiting and bad teeth. My impression is that this is something that Michael has reflected upon in hindsight rather than at the time. His father is curiously absent in the narrative, playing a far more subdued role. I found myself wondering whether he was also required to show his love for his wife by eating her food, and whether his ED was a way of reasserting some control over his life.

Peter’s experience of food within the home is very different from the other participants discussed in this subtheme. Instead of over-control, there seems to have been a lack of it:

Peter: *All I can say there is my family all have an eating disorder, so if you think about.... Again, if you think about....a family of.... You think about...a group of people, or a family who all have the same problem. [] The impact was that everyone had the same problem, so it became normalised. [] So it wasn’t really a problem. (Peter, 423-419)*

Rather than food being a means of control and coercion, his family’s relationship with it was so consistently disordered that disorder itself became the norm. I found myself reflecting on the lack of positive parental modelling in forming his relationship with food. Peter was unwilling to elaborate, and it was not clear to me whether this was because of a sense of loyalty to his family or because it remains a matter of deep distress (or shame?) to him; my impression was the latter.

3.3 Superordinate Theme 2: “I am a man” –Gendered bodies and identity

This theme looks at how the participants experience being male, and the impact that this has had on the development of their EDs. It is broken down into two subthemes, focussing on what being male means in the context of gender and sexual identity, and how men experience their bodies.

***Peter:** Because I need male identification. I am a man. (Peter, 854)*

Peter’s comments in relation to treatment will be discussed later in this chapter, but this statement, made in the context of his stated need for a male therapist, emphasises the importance of gender to his identity, and a belief that understanding from his therapist can only come through shared experience.

3.3.1 Subtheme 2a: “So imagine if you are a bloke” - What does it mean to be male?

Confusion over sexuality, gender-identity and conformity to male stereotypes features widely in participant narratives. This subtheme looks at the ways in which being male is experienced by participants. Accounts show that prior to developing an ED, aspects of sexuality and/or gender identity were significant concerns during childhood and adolescence for many participants, and in some instances, continue to be so. The title of this subtheme is taken from a comment made by Luke in explaining why he has never had formal treatment for his ED:

***Luke:** So imagine if you’re a bloke, which is a disadvantage for a start [] ‘cause you’re uglier than women...a woman.... You’re uglier than a woman for a start....And also....also, we just talk about rubbish. We don’t talk about personal things, generally. [] I think that’s fair to say. A fair assumption. Plu....Add that to being a shy bloke. Now you’ve got your double-whammy going on. Then you’ve got bulimia which is your triple-whammy. (Luke, 683-690)*

Luke’s statements are full of assumptions, including that men are uglier than women, that men talk nonsense (and, by implication, that women don’t!), and that men don’t talk about personal things. For Luke, the disadvantages of being a man (and he consciously uses the more macho label of “bloke”) are self-evident. He appears to assume that what

he says here will be shared by other men, as evidenced by his repeated use of the word “we”. It also appears directed towards me as the interviewer, inviting a sharing of these ideas. Although spoken with bravado, Luke’s comments imply a lack of confidence directly related to his gender, particularly in terms of body image, something that will be explored later (see Section 3.3.2). Luke’s stereotyping is extended to both genders, inviting men-versus-women comparisons, evidencing his sense of low male self-esteem.

Michael also adopts a comparative man-versus-woman approach, with the accompanying gender stereotypes. He paints a picture of what he considers to be the stereotypical view of society towards men with eating disorders:

***Michael:** It’s less socially unacceptable for a woman to be..erm...to..to..to experience an eating disorder than it is for a man. [] Men should be big and strong. Women should be....erm....small and slender and, erm.... Slim.... I mean...they’re just into stereotypes. (Michael, 1859-1865)*

By focussing on being “big and strong”, Michael associates having an ED with vulnerability. In terms of acceptance, he suggests that for a woman to have an ED conforms to societal expectations of vulnerability (and is therefore socially acceptable), whereas for a man it contradicts the expectations of size and strength. It is particularly interesting to note his belief that society expects women to be “small and slender” as this would imply, in Michael’s mind, an ED pathway more associated with AN than BED or BN.

Michael’s concerns seemed to be directed towards others’ perceptions of his ED:

***Michael:** At first I was worried that I’d be seen as being gay, [] Well, it was just my fear....I’d be perceived as gay because, well, you know, strong macho man. You shouldn’t have these namby-pamby things you’re worrying about. You should...should be able to....to look after yourself, like a big boy. Erm.... Like mummy’s little soldier....*

He is clearly anxious to assert his masculinity, and identifies this closely with his sexuality. For him, help-seeking is equated with effeminacy, which in turn he links (at least in the minds of others) with homosexuality. Michael makes frequent reference to phrases probably used by his mother (“like a big boy” and “Mummy’s little soldier”),

suggesting that she has played a significant role in colouring Michael's views of societal expectations.

Michael is tall, but nevertheless makes comparisons with women which suggest a degree of anxiety about his masculinity:

Michael:whatever we say about equality....the male is generally seen as being....It's the word I'm thinking of, so I'm going to say it....superior to women. But I mean physically stronger []would get on better in life. Or better than a woman....er....so....or strong....stronger, not better. (Michael, 812-823)

Michael is apologetic because he is aware that his words could be deemed chauvinistic, and this leads him to trip over them. My interpretation, however, is that he is anxious about not being able to live up to a stereotypical view of men, which he ascribes to society rather than exclusively (if at all) to himself. He does not appear to be saying that men *should* do better than women. Rather, he feels that men have a societal *expectation* to do better or be stronger than them, and Michael seems to have felt the impact of that. It is as if Michael seems to feel that men are judged by a higher yardstick than women, and I interpret this as something he finds oppressive rather than empowering.

Luke does not have Michael's fear of being seen as gay, and is at times deliberately camp. Nevertheless, he shares Michael's perception of a negative societal response to openness of feelings and, in particular, admitting to having an ED:

Luke: We're meant to be big hairy things.... What's that quote from Kenny Everett? [Slightly camp voice] "My dad always wanted me to be a big hairy thing. But I couldn't 'cause I'm a poof!" But I mean we're meant to be these big hairy things...and, you know, we're not. We're not meant to be talking about stuff like this. We're not... That's why....you'll find a few like me around, but you won't find many going through it. (Luke, 1101-1108)

By invoking Kenny Everett (a gay 1980s British DJ and TV entertainer), Luke draws a link between non-adherence to masculine stereotypes and perceived sexuality. He seems to imply that for men to be discussing EDs is going against a natural order. Although he sees himself as having recovered from the worst of his ED, Luke suggests that he would not have been able to discuss it when he was experiencing it at its worst.

I took from this a sense of secrecy and isolation for men with active EDs, something which is linked by Luke to reticence when it comes to help-seeking.

Rather than discussing societal stereotypes, Clive applies discussion of masculinity to his own physique:

***Clive:** I was already aware...that the kind of lads that I fancied were all the sort of sporty, athletic, rugby-playing types [] and they looked a certain way [] and they...spent a lot of time training. [] And, you know, and had kind of become....muscular rather than lithe, I supposed [] with their, you know, as they grew into their male bodies... And I was aware of that, and I wasn't. I was kind of.... A bit soft and rounded. [] By the time I got to my mid-teens I totally hated my body. (Clive, 1084-1096)*

He is comfortable in his sexuality but intensely self-critical of his body. He uses words which have more feminine connotations, in contrast to the more athletic look of the boys that he felt attracted to. Although Clive is confident in his ability to get on with women, his desired body image is strictly masculine. He appears to see soft, roundness as explicitly feminine, although this contrasts with his body hair, acquired with early-onset puberty (see Section 3.4.2). This creates a sense of gender ambiguity, with Clive seeing his body as both masculine and feminine.

Peter also appears to have shared Clive's sense of gender ambiguity in terms of body image:

***Peter:** When I was growing up fat, I felt completely emasculated [] because I looked at my body and it was.... My figure was round. [] My figure was more feminine. [] So I just ident... I didn't identify with a woman [] and I've never wanted to be a woman. Certainly never identified with any form of masculinity. I would... I went to an all-boys school. I...saw other boys' physique as I was growing older.... I became aware that I didn't have that, so therefore I wasn't really a boy. (Peter, 526-536)*

His use of the word "emasculated" is particularly powerful, conveying not only a sense of removal of identity, but also deprivation of virility and effectiveness. By seeing himself as appearing more feminine, without being able to identify with women, Peter appears to have felt as if he was in a gender void, neither boy nor girl. This is not presented as a middle-ground within a gender continuum, but rather an inability to have any form of gender identity.

Jack, also uses the word “emasculated” and contrasts this with the growing empowerment of women:

Jack: *But yeah, I've never....It's never been a thing. Never been a thing for me. And also, with the camp thing, I think we're growing up in a very androgynine society anyway. [] You look at the clothes, fashion. Men are.... You know, women are becoming more empowered and I think that leaves men feeling more and more emasculated. (Jack, 1277-1281)*

Unlike Peter, however, he refers to society as “androgynine”, suggesting a societal gender centre-ground in which masculinity is becoming increasingly irrelevant. I sensed that Jack does not equate the growing empowerment of women with a loss of their gender identity. His idea of an “androgynine” society is immediately followed by a discussion of the empowerment of women. It is as if women are *adding* masculinity to their femininity, appropriating it from men and thereby emasculating them. Although Jack appears to be painting a picture of a society in which men are required to become increasingly feminised, depriving them of the essence of their masculinity, this passage does not convey a sense of androgynous equality between the sexes. Instead of men joining women in an androgynous centre ground, to Jack it seems as if the ceding of their masculinity disempowers them and renders them sexless.

Two participants draw direct links between aspects of their androgeneity and their ED. Jo highlights the progressive effect of his ED:

Jo: *Erm, but then, as the disorder progressed, erm....I....lost that sense of fun and lost that....and lost, sort of, my identity as....male or female as a whole [.....] because I....wasn't really anything. I was just....I was just there. [] I didn't want to be there. I was just sort of.... [] I lost gender identity and sexual orientation. (Jo, 907-924)*

He describes his loss of gender identity and gender orientation, but I also detect a loss of his sense of personality as a whole (“I lost that sense of fun”). Rather than conveying a confusion about what he felt, Jo paints a picture of being devoid of feelings altogether (“I was just there”). Part of this seems to be because he is describing gender in binary terms, as either male or female. By seeing himself then as neither of these, it is as if he is also within a gender void, something that is reflected when he describes himself as

not being “really anything”. Although Jo does not go as far as saying he felt suicidal, he powerfully conveys a sense of not seeing the point in living (“I didn’t want to be there”).

Jo directly attributes his loss of gender identity and sexual orientation to the biological effects of his ED during puberty, although he is uncertain of the validity of his belief:

Jo: Part of that was, sort of, because I...managed to mess up puberty...erm...with the...because at the point where you're...you're supposed to get all your hormones in puberty, sort of does its thing [] I was...a...a...very, sort of, unhealthy physical state. (Jo, 907-924)

Many of the participants describe feelings of uncertainty about conformance to gender norms as a contributing factor to their ED, but in this passage Jo is attributing these to the effects of the ED itself. For Jo, the disruption of hormone production during puberty has played a key role in his current identification as non-binary.

Like Jo, Jack also attributes aspects of his behaviour to the hormonal disruption caused by his ED:

Jack: It's turned me camp. I found it hard to kind of associate with men [] ...the physiological reason is because, you know, the brain stops...secreting as much testosterone and it gets flooded with oestrogen. [] But [] I think the psychological answer...really is, I suppose, because I identified with being seventeen and I'm trying to go back to that place. Being silly, being fun. (Jack, 992-1000)

Jack explains these changes in terms of biochemistry, his ED having affected his hormone levels, but he is more interested in the psychological reasons behind his being “camp”. In emphasising his desire to return to his adolescence, Jack appears to be hinting at the darker side of having an ED, where things are not “silly”. This suggests Jack perceiving himself as not fun, ironic given his role as an entertainer.

3.3.2 Subtheme 2b: “I wish I had a better body” - Bodily change in childhood and early adulthood

Several participants drew attention to bodily dissatisfaction, and in particular to changes in body shape occurring during puberty. This subtheme explores these experiences, their impact on self-esteem and links to ED development. All participants appear to have struggled at some point with body image, and this is almost entirely

associated with weight gain, principally in childhood, although usually continuing into adulthood. This aspect of low self-esteem seems to be persistent, with most participants continuing to struggle with their attitudes towards their bodies, frequently associating it with the onset of their ED.

Gareth's weight gain during his early school years seems to have resulted in long-lasting issues with self-image:

Gareth: *After I went to school I started putting...a lot of weight on [] so I was really...quite...obese by the end of the time I was [] seven or eight [] and I was until, probably I was about.... Fourteen-fifteen, and then some of my weight...came off. [] I don't remember dieting or anything like that. Erm, but I still very..still very self-conscious and, erm had, you know, bits of bullying at school. (Gareth, 53-68)*

Like many participants, Gareth talks of his size as a schoolboy, drawing comparisons with other children in school, as well as his relative lack of height. Although he laughs, this is clearly something that continues to affect him. Gareth seems to attribute his self-consciousness to his weight gain, and links this to the bullying he received at school. Even though his weight fell subsequently, his issues with body-image have persisted.

Luke is unusual amongst the participants as he does not talk of being overweight as a child. For him, the weight gain appears to have begun once he had given up playing rugby as a young man. He then became aware of the increased difficulty of being able to adhere to the stereotypically-slim body expectations of the entertainment industry:

Luke: *... I was kind of podgy and...I knew my propensity to put weight on. [] So in order to keep up with this thin [] society I'd gone into [] I had to regulate myself. I had to...erm....to fit in. You know. And I didn't know quite how. [] And suddenly – I remember the urge – thinking, "I'll get rid of that prawn cocktail." With those.... 'For the sake of the tape the interviewee is sticking two fingers up'. [] So it was...it was less image, more fitting in. (Luke, 201-213)*

Luke's emphasis here is on "fitting in" rather than image per se, although it should be noted that the industry he was becoming a part of is very image-conscious. This comes across in the self-consciously theatrical manner in which he expresses himself. Phrases such as "for the sake of the tape", and his demonstration of the use of fingers to induce vomiting, demonstrate a strong awareness of image (it is part of his job). Luke is in

performance mode here, using his skills as a communicator to convey his point. This does not detract from his message about the need to fit in, which also conveys a sense of the insecurity felt on being propelled into a world of celebrity where fitting in requires being image conscious.

For Mark, increasing body weight also became a key precipitating factor in the development of his ED, his weight rising during puberty to over twenty stones by the age of fourteen:

Mark: *I'd got to about twenty stone and six pounds. That's two-hundred and eighty-six pounds. It's a lot of weight. And it's almost, or I think roughly, about a hundred and thirty kilograms, so quite [] heavy. [] I'm a bit...a bit heavy now but it's heavier than...I've ever been before. An', er, that was one of the initial triggers, along with so many other things. I just wanted to lose weight. Really badly....back then, so.... (Mark, 245-251)*

Mark describes this desire as “really intense”, conveying just how much it meant to him. There is a curious disparity between his use of the word “about” and the precision of his weight in lbs. Similarly, when he converts this figure “roughly” into kgs he is accurate to within 273gms (0.2%). There is no approximation in these figures – They clearly mean a lot to him and he seems to have monitored and analysed his weight to a high degree of accuracy. His observation that he is “a bit heavy now” (spoken hesitantly), in addition to his use of the words “back then”, makes me think that although he has lost a considerable amount of weight, he would still like to lose more.

Mark does not explicitly mention puberty, but it was during this period that his weight increased, and he seemed to have become more dissatisfied with his body. The onset of puberty brings about a range of physical changes and an increased awareness of his body as it becomes sexually mature. We have already seen that Clive had concerns about his physique in comparison with his peers (see Section 3.3.1). Puberty seems to have exacerbated this, starting as it did at the comparatively early age of twelve:

Clive: *...but there was always conflicting messages about it, so....I was given the kind of the birds and the bees style talk and the ...you know...I knew what to expect....Er....technically. From a...you know. On paper, in a text-book kind of way. I just wasn't prepared for it starting so early. And*

I was really embarrassed about that, so you know things like facial hair and...pubic hair and all that kind of stuff. (Clive, 594-599)

Clive's embarrassment seems to stem from the early onset of his puberty, probably setting him apart from his peers. A distinction is drawn between theory and actuality. Clive mentions the "birds-and-the-bees-style" talk and "text-book" knowledge that he has acquired, but there is no sense of being prepared for the emotional and psychological impact of puberty. His subsequent lack of height and non-adherence to stereotypes of masculine physique seem to have exacerbated what comes across as shame in relation to his body image.

For Jack, puberty brought about an increased (and more sexualised) interest in girls, and an idealised body image was of increasing importance (and remains so) in attracting their attention:

Jack: *I'm...I was very embarrassed about it and...still I don't really talk that openly about it, but I think actually the sex thing was a huge thing. [] It felt like it being a, you know, a [] seventeen-year-old boy, like everyone, everyone was losing their virginity and I was still this chubby little kid. [] And I think it was kinda like...acceptance thing. So, I was like, I've got to lose weight. (Jack, 159-168)*

Jack is very self-conscious when talking about sex and how big an issue it was as an adolescent. That it remains so is clear from his initial use of the present tense ("I'm") and his reluctance to talk about it. He attributes his early lack of success in forming relationships (and losing his virginity) to being overweight. This passage conveys a sense of Jack feeling left behind. There is strong black-and-white thinking ("no one's ever gonna"), and an emphasis on "acceptance", as if he will only truly belong if he loses his virginity.

Peter's reflections on his body-image result in powerful feelings of embarrassment and shame (see section 3.4.2) concerning his inability to live up to societal ideals of the male body:

Peter: *This shame of having...shame of a man.... I wish I was taller. I wish I was more masculine. I wish I had a better body. All of that stuff. The shame of being that kid who was growing up with....a body that I couldn't relate to boys, I couldn't relate to other men, because I didn't have that look [] The shame I felt [] An eating disorder is fucking awful and*

debilitating and terrible and it kill...it kills people.... You know. It's very...It's very subtle...but it does kill people (Peter, 1059-1066).

Peter's repetition of the word "shame" conveys the powerful intensity of his feelings. He links his shame directly to his gender, as if it is an emotion that he feels is shared by many other men. He runs it off quickly, like a well-rehearsed list of defects, before speaking passionately about the sense of otherness that he felt because he could not relate his body to those of other men. By emphasising the potentially deadly consequences of EDs, Peter is reminding us of where this sense of alienation can lead to.

Michael draws comparisons between male and female versions of body ideals. He begins by expressing his belief that for women there is a pressure to conform to a single, supermodel ideal of bodily perfection, and compares this with what he sees to be the situation for men:

Michael: *'Cause with men [] You've got different extremes of what it might..might be. [] It could be someone like [] Oh. I can't think of his name. The general...the rugby player, erm.... [] Broad shoulders [] May weigh eighteen to twenty stone [] But not an ounce of fat on him. [] Or it could be the, erm... someone like Zachary Quinto [] who...s..sort of fairly slender.... (Michael, 1898-1912)*

Michael is highlighting a perceived societal pressure to conform with particular body ideals, but he also seems to believe that men are faced with competing ideals of physical perfection. He contrasts the muscular, rugby-player body ideal with the slimmer, but still toned, look of the actor Zachary Quinto, and goes on to say:

Michael: *But I suppose the thing they all have in common is fit and...fit and lean. (Michael, 1928)*

Michael seems to see both extremes as unhelpful, possibly a reflection of his own attempts to conform though his ED. As someone who was overweight as a boy, these varying images of athleticism seem to engender feelings of resentment in Michael. Rather than giving greater opportunities for compliance, I sense that having more than one standard of bodily perfection to aspire to simply increases Michael's feelings of inadequacy by being unable to meet either of them.

3.4 Superordinate Theme 3: “It’s a control....that’s out of control” – The need for, and loss of, power and control.

Lack of, and need for, control forms a major part of participant narratives. This is explored through four subthemes. The first of these looks at lack of visibility and the sense of powerlessness that this imbues in participants. The second explores shame and the loss of emotional control. The third looks at secrecy and the exertion of power over others. The final one looks at the inevitable loss of control caused by the ED.

3.4.1 Subtheme 3a: “I wanted to be visible.” – Being invisible.

Participants’ lack of control over their lives often manifests itself in a feeling of invisibility. Their ability to shape their lives is compromised by their inability to gain the attention of others. There is an irony here, however, as this is often combined with a desire not to draw attention to themselves, whether through a desire to fit in, or to avoid the attention of bullies. This subtheme looks at visibility, something that is both desired and shunned.

With the exception of when he was buying food for a binge, Jo has not sought to hide himself. He explains his ED as an antidote to the less successful aspects of his life:

Jo: Erm.... Because I hadn't been able to... I wasn't able to have any real effect on anything else or anyone else, and I wanted to be... I wanted to be noticed. [] Erm. I wanted to be seen to be...to be the best. (Jo, 589-592)

Ironically, for a variety of reasons, often directly linked to his gender, this strategy does not seem to have been successful. Jo recounts his experience of assessment at a specialist NHS ED unit:

Jo: they were very much...giving the impression that I wasn't worth their time because I didn't fit their criteria..... Erm....and so there'd be a lot of checklists, a lot of ticky boxes...erm.... “Well, now, do you have an eating disorder?” Erm... So I got asked on more than one occasion if my periods had stopped. Erm...which.... It just...They weren't paying attention to me at all. (Jo, 280-284)

He paints a remarkable picture of the health professional quite literally not seeing him for who he is. Their failure to notice his gender, and use of a form designed for women and

not for men, underlines what he perceives to be their lack of interest. There is a stark contrast between his desire to be noticed and this resulting lack of attention. This is further reinforced by a failure to follow up when he misses an appointment:

Jo: *So, then I'd miss an appointment, but they wouldn't try and follow up or, you know, try and see if...if I was...there was a reason for that. (Jo, 287-288)*

The result is that they don't pay him attention when he is there, and they fail to notice when he is not.

For Jo, this problem is exacerbated by his non-binary self-identification. His comments are aimed at society in general, but they also seem to match his experience of mental health support for EDs:

Jo: *...there's the non-binary group who just don't...don't exist as far as people are concerned. [] Anybody who's not black or white...in terms of sexual-orientation or gender identity...is shunted under the carpet [] and seen to not exist. []it increases the [] the lack of self-acceptance...ahm....and self-validation.... (Jo, 1226-1234)*

Jo is very much aware of his “other” status as a man (see Section 3.5.1), and this is exacerbated by his gender identification, and has a profoundly negative impact on the quality of care that he receives.

Peter describes his friends as outcasts, set apart from the mainstream:

Peter: *Erm... I..had...friends...who...they were, kind of outcasts, rather like me.... [] Who didn't fit into the norm. The prescribed norm. [] So I kinda had friends but it was like the people who are always left at the end of not being picked for games. (Peter, 448-453)*

It is interesting that Peter is reluctant to describe himself in these terms. Rather, he seems to portray himself as an outcast by association, by being among those whose invisibility comes from being rejected through their inability to match what he reinforces by calling “The prescribed” norm. Peter appears to want to be part of the mainstream, and to have his abilities recognised:

Peter: *I...I was someone who used to sit around and wait for something to happen [] and it never did. I would go to a job and wait to be discovered, or, you know.... Hidden talents I had, someone would just phone me up and say, “Hi! We've heard about you. You're amazing. Come and work in this company. [] And it's never fucking happened, and I would sit around waiting for it. (Peter, 1308-1314)*

He is recounting this story to show how he has changed, and he conveys effectively a sense of entitlement, along with anger that his abilities *weren't* recognised. Ironically, he is waiting to be chosen, recalling his friends not being picked for games, suggesting that Peter does see himself as an outcast alongside them.

Peter develops the sense of isolation felt by ED sufferers:

Peter: *You know, having an eating disorder is about disconnection with the World. It's about being isolated and inauthentic and frightened and, you know, all the words I associate... The negative words always associated with eating disorders are about fear and isolation and shame and not wanting to be seen. (Peter, 1395-1398)*

He links the two aspects of being invisible here: the first is “being isolated”, i.e. cast out by others. The second, however, is “not wanting to be seen”, i.e. making oneself invisible. The two seem to coexist effortlessly in the World Peter describes, and seem to be mutually fulfilling. Peter also draws attention to the inauthentic nature of this ED World, suggesting that it masks personalities rather than encouraging their true expression.

This self-isolation features in Gareth's narrative:

Gareth: *....I was kind of very....very shy, erm, so sort of going to anything with, erm, sort of groups, groups of adults, I found.... You know, I just wanted to...hide away, really. [] You know. And not draw attention to myself in any way. (Gareth 573-577)*

His shyness leads him to withdraw, not wanting to be noticed, but he is also aware of the consequences of this:

Gareth: *Erm.... And, er.... So I...I...I dunno. I... I kinda felt....Well, it was kinda like marginalised. Well, I'd marginalised myself within a marginalised group, in a way. (Gareth, 1196-1197)*

Gareth realises that the marginalisation is, to a large extent, self-created. Nevertheless, he still refers to the group as “marginalised”, suggesting that he attributes some agency to society as well as to himself. Peter and Gareth's accounts of isolation and lack of visibility are not, in themselves, obviously gendered, but take on more meaning in the context of having an ED to which their gender does not seem to belong.

Mark discusses isolation in the context of a secret online support group he is a member of. When asked about the purpose of it, he responds:

Mark: *Er, I think, to tackle....loneliness. Because I think [] the person who created it wanted friends. Also to express....erm....everything. [] You can acknowledge [] everything I sort of experience in a day, the worst parts, I can discuss it with no worries. I can say, "Oh yesterday...I did this, this and this." I've lost weight since. I'm very happy. (Mark, 1161-1170)*

It is ironic that in joining this group, Mark has found friendship and support in the most invisible way possible. He can express himself in whatever ways he wants, but he does not have to be seen or even known. It allows him to develop human contact whilst at the same time remaining secretive. I wondered to what extent being connected but invisible enables Mark to set aside any issues he has with his body, and how it fits with societal ideals of male perfection.

3.4.2 Subtheme 3b: “This [....] shame of a man” – Loss of emotional control.

Shame and anger are frequently mentioned by participants with reference to lack of control and self-control. Often this is associated with the act of binge eating and resulting feelings of shame, something that is not unique to men. Other aspects link to the concepts of masculinity and the perceived failure of participants to live up to these ideals. This subtheme examines the emotional response of men with EDs to the lack of control over their lives and eating.

Jo grew up under the shadow of his father's domestic violence, (see Section 3.2.1). Along with the physical comparisons made by others, he compares his behaviour to that of his father:

Jo: *...erm...but then at one point I lost...I...I lost the way....erm...and I began to see that I was always going to be like him because, you know, I...I...I...I lost control of my moods so...erm...and any challenge to...to sort of disordered behaviour, resulted in...in, sort of aggression, I guess. Erm, so I took it that I was...I was fated to be like him, so it ended up just becoming, erm, sort of a...a race to self-destruction in a way. (Jo, 437-441)*

Jo talks of losing control of his moods when his behaviour comes under criticism, reacting aggressively to challenges. His account suggests that he once saw this as predestined – as if he literally has no control over behaviour that is “fated” to be like that of his father. I wondered to what extent this interpretation provided a form of protection against

assuming responsibility for his actions. The words “I took it” suggest that he reflects differently upon this now, “self-destructive” emphasising that that is something brought upon himself. It is also suggestive of self-inflicted violence. Jo’s experience of male expression of anger has been his father’s domestic violence. He does not want to be like his father, whose anger made Jo and his family feel unsafe. Nevertheless, Jo’s principal model of the expression of anger has been through violence, so it would make sense for him to use this model but to direct it in on himself in the form of BN.

Whereas Jo’s behaviour is expressed outwards in the form of aggression, Clive experiences intense feelings of shame centred around his ED. His narrative contains an implicit criticism of the categorisation of eating disorders (he begins by referring to his “eating disorder” rather than BN or BED), but curiously none directed towards the treatment he has received. Clive elaborates on the differences in naming between BED and BN. In discussing “bulimia”, he says:

Clive: *There’s something a bit...erm...less shaming about...the word and what it’s come to mean because of the media and the press and stuff. [] But Binge Eating Disorder...I think...Well....it’s got the word “Binge” in, for a start [] and, you know.... Er, and normally a lot of people with binge-eating disorder, and I’m no exception, are overweight...and so people...I feel quite ashamed of that epithet. (Clive, 241-247)*

Unlike AN and BN with their roots in Greek, BED is English and highly descriptive. Clive focusses on the word “binge” and the negative connotations associated with it. He sees it as “shaming”, especially when those suffering from it are often overweight and have significant issues with body image. At first, he talks about the effect it has on other people, but then goes on to own it himself.

We have seen that Clive also has feelings of shame associated with his early-onset puberty and the body changes that this brought about (see Section 3.3.2). In particular, he speaks of embarrassment caused by exposure to male changing-room banter:

Clive: *Other lads were [] chuffed to bits about getting...hairy and big and [] getting a bigger penis, and I was just thoroughly embarrassed. It was horrendous. [] And I didn’t like all of that talk. [] I didn’t feel comfortable with it. So then that was one of the places I felt very under threat []*

because I couldn't...I couldn't control that. [] You know, this was a particular environment where...boys were all being boys together....(Clive, 934-945)

Boys “all being boys” seems to have caused Clive intense distress, and I wondered to what extent this is due to him not feeling all-boy because of his perceived failure to match societal ideals for male body types. Clive describes feeling threatened in an environment that would have been literally exposing, and links his distress very clearly to his inability to control the situation.

We have already seen Peter’s sense of shame in association with his body image (see Section 3.3.2), with its linkage to the alienation he felt as a child. He also talks of shame when comparing EDs with addictions, and discussing the social habits of drinking. He observes that many alcoholics like to party:

***Peter:** But, I don't...if I'm in active addiction with my food....[]I don't invite all my friends round and, [raises voice] “Let's all get fucking...hammered on food. Let us all, like, binge together.” And that just doesn't happen. [] An eating disorder's private. [] It's...it's shameful. It's shame-induced. Erm... Er, it's secret. (Peter, 774-781)*

He substitutes food for alcohol to comic effect (“hammered on food”), but what he is highlighting is the lack of glamour associated with overeating in comparison with some portrayals of heavy drinking. Peter’s juxtaposition of the phrases “it’s shameful” and “it’s shame-induced” suggests that not only does the ED cause shame, but also that it is caused by it, something that fits with Peter’s shame narrative

Gareth also draws together his ED and drinking, and discusses the fear of exposure and the shame this would bring:

***Gareth:** I mean with the...with the drinking and the eating..that kind of.... I suppose the secrecy and....the....holding on to it, and not wanting to be exposed...in some way. You know. Not wanting it to get out...because then people would see how terrible I am, or how weak I am, or.... It would be very shameful. I think there's a lot of shame mixed up....(Peter, 1544-1548)*

He links his eating with his drinking, suggesting that he sees them both as addictive behaviours, and emphasise the hidden nature of them (“the secrecy”, “be exposed”, “not wanting it to get out”). His concern seems to be that people will see him for who he thinks

he really is (“terrible” and “weak”). It suggests that the shame he says he feels is directed more towards himself as a person than to the ED behaviours he is exhibiting.

Michael’s narrative conveys the power that fear of exposure can have for men with EDs. Looking back, he struggles to think of anything that would have caused him to change his behaviour:

Michael: *And frankly I can't think of a thing. [] Erm.... Apart from abject and total humiliation by being caught out. [] Erm.... but I'm not sure quite wh....[laughing] where that would have ended. [] Erm... My.... And that...If I'd been caught out, that level of humiliation....could possibly have even ended up with suicide. [] 'Cause that would be how much of a horror it would have been to be caught out. [] Yeah, I re....God. Thinking.... It could easily have ended up that way. [] God, that's a frightening thought, isn't it? (Michael, 1716-1729)*

Michael laughs, appearing to use humour to deflect the power of the thought of being caught. He repeats the word “humiliation”, and talks of “the horror” of being caught out. Suicide seems to him to be a logical response to this, and he is struck (and frightened) on reflecting how easily this might have happened. Listening to Michael’s narrative, I am struck by the importance of secrecy. Here Michael is saying that it is potentially a matter of life and death.

3.4.3 Subtheme 3c: “It was my secret [....] power over everybody” – Exerting control

In response to this sense of powerlessness, many participants describe a need to exert control over aspects of their lives, be it management of their time, what they wore, what they did, or even exerting control over others. This subtheme explores what seems to be a common factor in the exercise of control as a coping mechanism, frequently for emotional regulation and feeling better about themselves.

Power is important for Michael and Jo in their approaches to therapy. Michael at times seems to have used therapy more as a game than as a means of getting better:

Michael: *A bit of me was playing the game, I think [] because.... In a way, what we've been talking about just is kind of CBT-based in the sense that looking at logical [] evidence.... I spent thirty years of my life....looking at evidence [] so, when it comes to drawing evidence...er, well, putting together evidence....of something....I....doesn't really....hold much fear for me. (Michael, 961-969)*

As someone involved in investigating for a living, Michael is able to grasp the theory behind CBT and feel a sense of power over his therapist. He calls it a game, but only he seems to be aware that he is taking part in it. Michael draws a distinction between expert and average CBT practitioners:

Michael: *And you've got, erm.... One CBT practitioner, who perhaps is absolutely amazing at it, someone else who does it in...in the sense of following....follows the instructions, or the recipe in the recipe book. [] Erm....and, I think, unfortunately, I was able to follow the recipe in the recipe book....because that's....what....what they've been taught. (Michael, 961-979)*

His comparison of CBT protocols to recipes conveys a degree of contempt for this approach to treatment, as well as to the therapists who are applying it inexpertly. There is a fragility in Michael that seems to lead him to want to prove himself, even when seeking help. By learning the rules of the CBT game, he is able to place himself in a winning position in relation to his therapist. His emphasis on “evidence” makes me wonder if this is his primary means of control: being selective in the information he shares. This is despite voluntarily seeking help.

In responding to why he was not fully forthcoming when going to his GP, Michael provides another example of control being the reason for initial non-engagement in therapy:

Michael: *(long pause) There's a certain amount of power in [] knowing you're the only one with a secret. [] Partly embarrassment.... Erm..... Not wanting to admit it....erm....but partly power in knowing, "I'm the only one who knows this", whereas in fact I wasn't, but....at work very few people know I, erm....had an eating disorder.... (Michael, 753-756)*

Michael hesitates for a long time, but he eventually acknowledges his desire for power and to feel in control in relation to his GP. He admits to embarrassment, underlining the shame associated with being a man with an ED, but there is also a sense of pride. He is honest about enjoying the feelings of power and superiority that come with secrecy. Michael appears to have used secrecy as a means of asserting control over his life, and by sharing his secret with others, he is in danger of relinquishing that control. Embarrassment is also there as a key motivator for withholding, meaning that Michael's

eventual openness with his doctor requires him to make himself vulnerable, something that it feels to me runs counter to his notions of masculinity.

Like Michael, Jo is also a reluctant client for therapy, only attending because of his mother's concern:

Jo: On some occasions I...I'd go there...for....I guess the thrill of being able to...to...to...fool the professionals as well [] because that meant that I was really good. [] Wanting to show that there was nothing wrong with what I was doing [] I was being told that there was something wrong by my mother but I was able to go there and prove that there wasn't [] anything wrong. [] Because of the complete lack of....attention that was being paid [] it wasn't difficult. (Jo, 605-621)

The need to be the best seems to override his interest in recovery and becomes a form of self-validation. Jo is more explicit than Michael in wanting to “fool the professionals”, but for both there is a sense of fragile underlying egos. Even allowing for Jo's post-recovery perspective, there is pride in his belief in his ability to hide his ED from his therapists. There is an interesting tension in the language used in that he sought to prove that “there was nothing wrong” when his admission of deception demonstrates that he knew that this was not true. In being successful, Jo can show that is was “really good”, again helping to reinforce his ego. By implication, as well as beating the professionals, he is also proving his mother wrong, thereby reasserting some control in their relationship.

We see Jo's power over his mother exerted further during his AN phase, on occasions going all day without eating:

Jo: But with this I'd win every time....because there wasn't anything that I wasn't prepared to do...to be right, 'cause nothing compared to the feeling where it was the end of the day and then I'd get it out, either that I hadn't had anything...all day and...it was...it was a very empowering feeling seeing her panic...because then I knew that I was...I was doing it right. (Jo, 584-587)

Controlling his food intake is empowering for Jo, and his mother's panic provides the litmus for measuring the effectiveness of his actions. Jo's language is highly competitive, conveying an impression of a no-holds-barred battle to win. This is clarified by his observations on his behaviour:

Jo: I didn't have...ever have any issues with lying or manipulation. [] It was...it was my secret...secret power over everybody. [] It felt like I was actually in control. [] I thought I had... I thought I had it all. I thought I had everything under control...because I planned to keep on going that way forever. (Jo, 514-525)

Jo emphasises the secrecy of this power and his belief in the control that he has over the situation. It comes across as a hollow victory, however, as he is winning in a competition that his mother neither understands nor fully realises that she is participating in.

Jack's exertion of power is less outwardly manipulative, but does also involve secrecy. His AN behaviour allows him to exert control in a life that seems otherwise threatening, allowing him to rise above mundane pressures to something greater:

Jack:C.... []which was my weight, my restricting, my calories, that...if I could win at that kind of stuff, the higher-level stuff then everything in life would fit in. (Jack, 60-69)

Like Michael and Jo, Jack invokes a sense of competition, but there is no talk of fooling others. Rather, it is as if he is competing with himself, achieving his own self-enforced standards of success. The secrecy is important, however, as Jack is fully-aware of the potential outcomes of his actions:

Jack: It was my goal. It was my thing. It was something I owned. And yeah, I was ending my own life....erm...but I was in a very lucky position because I, you know, it could come at any time, I was very careful to make sure...to put things in place so that people wouldn't be so bereft. (Jack, 132-135)

Jack realises that if continued, his actions will inevitably lead to his death, and this is the reason for his secrecy with others. His acceptance of death is in keeping with his drive for perfection: Dying will provide confirmation that he has reached this "omniscient" state.

3.4.4 Subtheme 3d: "I...managed to control it [...] but it ended up controlling me" – Control, and loss of control, of food

All participants appear to have experienced the paradox of their ED being a manifestation of both control and a lack of it. A strong feature of their narratives is comparisons with addiction and loss of awareness when losing control of eating. This

subtheme explores their experience of using food as a means of regulation (both emotional and physical), and the inevitable loss of control that this leads to.

For some participants, this loss of control seems to have dated back to childhood. Clive reflects on loss of control in the context of avoiding thinking about, or using names for, his ED. When he does apply epithets, they are very judgemental:

Clive: *All my names were stuff from my childhood, you know, about being greedy and about being....erm....lacking self-discipline....[]and having no self-control, and...and not having any willpower.*

Clive does not say where these names come from, but they sound as if they were applied to him as a child by adults with authority over him. There is an emphasis on lack of control, not having “self-discipline”, “self-control” or “willpower”. I considered that as much as reflecting a reality, these comments probably helped to shape Clive, suggesting, as they do, a lack of agency on his part.

Jo paints a vivid picture of what it was like when he lost control over his eating:

Jo: *Erm... I'd often eat, like, straight from the can, so I'd end up cutting my mouth open. [] Erm.... But it was never something that I was....really aware of or in control of.... Erm, but then after...after that sort of period passed there would be....waves of guilt. I'd often go out and replace the food, any food that I'd taken from the sort of family kitchen.... (Jo, 36-40)*

He describes neither being “aware of” nor “in control of” what he was doing when bingeing, something which contrasts with the physical injury he was inflicting on himself when eating from a can. He does not seem to have noticed the pain. Awareness seems to have brought an emotional response of guilt, although I wondered to what extent replacing the food was as much about maintaining secrecy as it was to make reparation. Jo talks of using over-the-counter sleep medication to calm his hyperactivity and control his moods:

Jo: *Erm.... But, I guess it was more for the placebo of...of, you know, “I've had this. Now I can calm down.” [] Erm... but then, naturally that ended up sort of escalating....to...to...you know.... requiring a full box to...to sort of be able to sort of function throughout the day as opposed to...constantly feeling hyperactive and....[] it would help that I was...I was inputting....obscene amounts of...of energy....[] Erm...but... I felt like I desperately needed to have any kind of sort of grip.... (Jo, 197-209)*

His need for any “sort of grip” implies a loss of control as a result of his ED, and he acknowledges that this is probably attributable to the large number of calories that he is consuming. His use of the word “obscene” is loaded with self-judgement and emphasises the abnormality of his eating. Ironically, his efforts to control his eating and his emotions using medication themselves result in a loss of control as it takes ever-larger amounts to obtain the same effect. His use of the word “function” suggests no joy in his life, the emphasis instead being on simply existing.

This idea of moving from control to lack of control is visible in Mark’s pride in what he sees as control over his eating:

Mark: *Because taking aside the fact that I do eat a lot on a day, because I’m purging it’s sort of cancelled out as well. [] Er.... But that’s the most recent thing. There have been days where it’s not stuck...exclusively to that cycle. Some day...some days I will eat outside of that. And if I do eat outside of that I will binge eat. So I’ve had many more days at that recently, so....’s all over the place. (Mark, 669-674)*

Mark regards his purging as a form of regulation that justifies the bingeing. The phrase “cancelled out” has connotations of balance, but I also wondered whether Mark had in mind recompense for a misdemeanour. Mark portrays this as having a sense of order, but this view rapidly changes when he admits that more recently his over-eating has turned into bingeing episodes. His description of his eating as being “all over the place” is in sharp contrast to the way he initially portrays the current state of his ED.

Like Mark, Michael’s narrative draws together these themes and builds on them:

Michael: *....Because the perception is, if somebody eats a lot....they’re big. [] But I wasn’t. But I never appeared to have weight problems. Because I didn’t. Erm, because I...managed to control it. [] Erm....but it ended up controlling me. (Michael, 777-782)*

His words combine secrecy (his ability to control what others know about his behaviour), control of his eating and weight, and his ultimate loss of control. As spoken, “It” appears to refer to his weight, but I sense that what he really felt controlled by was his ED.

Michael talks with pride about his ability to regurgitate food at will, something he still regards as a “skill”. However, he recounts losing this control when his ED developed

to a point where he could not eat *without* regurgitating. He describes these events as fits and compares them with the loss of consciousness associated with epilepsy:

Michael: *But with this I was fully conscious, and, and knew exactly what's going on, erm, but would have massive shakes and my, my stomach would be.... I was convulsing and trying to force the food back out. [] And.... That's where....it's a disorder, not a skill. [] I physically couldn't do anything about it. Erm....and that was horrible. (Michael, 514-522)*

For Michael, this represents a loss of control of his body as well as his actions. The picture he paints is horrifyingly descriptive, as if he is reliving it in the telling.

Peter draws a link between the inability to control eating and addiction.:

Peter: *And I will go in and out, and the high I get and the withdrawal I get, and the...the fear I get....is all...is all part of that journey [] and the fucked-up thing is I never know...how that...where that's gonna come out, 'cause I've got no control over any of it. [] It's terrible. It's an awful, awful, awful disease. It's terrible. (Peter, 287-293)*

He is consciously using the language of addiction, speaking of the “high” and “withdrawal”, as well as having “no control”. This lack of control is associated with not knowing and fear. Peter’s passion comes through strongly, using words like “fucked up”, and the repeated use of the word “awful” to convey how he feels about his ED. He becomes more explicit in the classification of his ED as an addiction. When talking of sweets or biscuits, he emphasises his inability to have just one, and says that it is not only unhealthy, high-carbohydrate foods that he cannot control his consumption of:

Peter: *....even if you had a plate and broccoli there.... It's not about the food...itself. It's about the action. I can never, ever have one. [] So.... That admission...because I can't control it....[] (whispering)with everything. (Normal voice) You know, I am an addict. (Peter, 12276-1236)*

Peter is making a clear statement about his inability to control his consumption of food in general, and does so in a way that uses the language of surrender employed in twelve-step programmes (see Section 3.5.2). The whispering, when talking about the extent of his lack of control, conveys shame, but there is something empowering about his simple acceptance of being an addict.

For Luke, the lack of awareness experienced by many participants when bingeing extends as far as sleep-eating:

Luke: *I would rope myself to the bed at night...because I used to sleep-eat. So I used to eat in the middle of the night....A lot. [] I'd tie ropes...rope my legs to the bed. [] So that if...when I woke up to go to the pantry or wherever it was, I'd go, "Oaagh!" and I'd wake up. (Luke, 315-322)*

Being asleep, he is literally not conscious of his actions, and knowing the possible outcomes, he takes steps to force awareness upon himself by ensuring that he will waken if he tries to get out of bed. Luke paints a startling picture of what used to happen when he sleep-ate. Describing the support given to him by his wife, he says:

Luke: *Erm....But she would often find me trapped....in the hatch of the kitchen....literally stuck, trying to get through the hatch. 'Cause she would bolt the kitchen door. I would get up....attempt to get into the kitchen and find myself stuck. And off...twice had to...call her out of bed to come and get me. (Luke, 329-331)*

At his request, his wife has locked the kitchen door, but this does not prevent him from finding other ways to access the food there. Luke is telling this story to comic effect, but the picture it paints of loss of control is quite horrifying. There is a sense of exaggeration, but this quickly becomes rooted in reality when he corrects “often” for “twice”. Behind the telling of this story by a professional entertainer for its dramatic effect, is a very real sense that this happened.

Luke uses the analogy of alcohol addiction to explain his binges, which also occur when he is awake:

Luke: *I don't know. It's a control but that's...[half laughing] It's a control that's...mechanism that's out of control....It's a steady thing that you know is there, and yet... When you're walking past that bloody supermarket.... [] I've always drunk too much. Always. So....when I go to Waitrose...."Don't get any vodka. Don't get any vodka. Half a vodka, please.... Oh! I did it! Damn! Damn!" (Luke, 1197-1201)*

In comparing his ED with alcoholism, Luke seems to be conveying a sense of lack of physical and psychological control over his food. He portrays it as a mental battle that he is trying to fight but inevitably losing. There is an awareness (“half a vodka please”) but also a lack of awareness (“Oh! I did it!), followed by the inevitable recrimination.

3.5 Superordinate Theme 4: “You’re a shy bloke and you’ve got Bulimia. So where the hell do you go?” – Experiences of help seeking.

Not all participants would describe themselves as shy, and most have at some point sought help. Nevertheless, this has often been a reluctant step, with some only taking their first steps as they approach middle age. Luke builds on his belief that being a man is in itself disadvantageous (see Section 3.3.1):

***Luke:** So not only are you a bloke. You’re a shy bloke...and you’ve got bulimia.... So where the hell do you go? You are screwed. You are suffering in silence, as they say. (Luke, 690-692)*

Luke feels that men by their very nature are disinclined to discuss their feelings, and points out that this becomes worse when added to by the shyness and insecurity experienced by many ED sufferers. As a result, men with EDs frequently have difficulty seeking help in a system that is not set up to meet their needs. This theme is divided into two subthemes, the first exploring alienation of men seeking help and the second experiences of therapy meeting their needs.

3.5.1 Subtheme 4a: “We don’t normally...speak to men” – Men as other.

Men are often seen as not fitting into the therapeutic mould where ED services are geared primarily towards the needs of women. This inevitably leads to a sense of alienation, often resulting in disengagement from the therapeutic process. This subtheme explores this lack of recognition for men and their needs in the help-seeking process.

Unlike most of the participants, Clive’s initial approach for support was made to an ED charity:

***Clive:** And the helpline person was just utterly flummoxed. [...] “Oh, we don’t normally support.... We don’t normally...speak to men” [...] or whatever. It’s like, “Okay. But you’re speaking to one now. Have you got any....” [Laughs] [...] “...anything you can send me... A bit of literature. Something. Anything!” (Clive, 1641-1647)*

He acknowledges that the situation has changed since then, but his experience was of an organisation ill-equipped to cater for enquiries from men. The initial response is very discouraging, and although Clive sees the funny side of it now, it seems remarkable that he persisted. His recounting of it employs a sense of desperation to comic effect (“Something. Anything!”).

When Clive receives the literature from the ED charity, he finds that it is aimed at women rather than men, reinforcing the assumption that EDs are a female problem:

Clive: you know, all the language was...was feminine pronouns and [...] And, er, about periods and....periods being going, periods coming back and.... [...] It was just, yet again, you know [...] the half man, half woman [...] I do remember having a bit of a wry smile to myself and thinking, “Oh well. That’s par for the course, isn’t it?” You know. [Laughs] Trust me to get a... a bit of a female disorder.... (Clive, 1649-1672)

Clive cannot disguise the vulnerability which becomes apparent as he reflects upon the literature that was sent. The highly-gendered nature of this seems to have fed his anxieties concerning gender identity, causing him to buy-in to the charity’s inadvertent assumption of EDs being something that only women suffer from. Having garnered the courage to make the call, there is something enormously disempowering in the response he receives, the effect being visible in his disillusionment (“Oh well. That’s par for the course, isn’t it?”).

At the time of being interviewed, Gareth had only recently been assessed for treatment at a specialist ED unit, and his experience of initial engagement was also not encouraging:

Gareth: And he made this analogy. He’s saying, “Well, you know. You’re not eating enough.” And he says, “You know when Lewis Hamilton’s going round the racetrack, you know, and his car needs....fuel and what happens if he doesn’t go in for a pit stop,” and it’s kind of, Jesus! How old am I? [...] You know. Is..is..is this the... Is this the male take on treatment? Racing cars? (Gareth, 1768-1773)

Gareth experiences this attempt to appeal to a male audience as patronising and infantilising. There is an implicit assumption that all men are interested in Formula One which seems to me to be as inappropriate as assuming that all women like shopping. Gareth’s exasperation is clear as he says, “Jesus”. Fortunately, he channels his anger

positively, going on to say that he intends to discuss his concerns at his next appointment rather than disengage.

Jo describes the way his gender has hindered his experience of therapy and acceptance by the therapists themselves:

Jo: The response that I received was....never...especially positive. At the time that I was presenting as a heterosexual, switch-gendered male...erm....and the general attitude was that I...I wasn't considered...to be a real problem because of my...erm...gender and sexual orientation. (Jo, 264-266)

For Jo, ED services are inflexible and unable to adapt to presentations beyond their normal range of experience. He finds himself being treated as an unrecognised category rather than an individual seeking help. Jo speaks further about the feminisation of EDs:

Jo: Erm... For some insane reason, eating and exercise disorders was still viewed as...a feminine issue [] so it's either going to affect....females or gay males, which is also feminising homosexuality, but...that's a...that's a different...that's a different matter. (Jo, 266-270)

He draws attention to the linking of homosexuality with femininity, suggesting a perceived confusion between gender and sexuality within ED services.

Jo: All the resources were aimed at females [] I mean, I had my weight checked one time....erm...and it was...it was...checked against teenage female weights....erm, and for someone who's...biologically male that's...a really bad idea, because it's a different...it's a different structure. Erm. And biological males are naturally...generally heavier than biological females. (Jo, 273-278)

This use of female-gendered resources links to Jo's experience of being asked if he is still getting his periods (see Section 3.4.1). Not only are the resources supplied by the ED service aimed at women, but on one occasion, therapists use inappropriate measures to ascertain his body mass index (BMI), something that could potentially mask the seriousness of his condition, given that he was at times suffering from AN.

Jo only went into therapy at the insistence of his mother, and we have already seen his attempts to outwit his therapists (see Section 3.4.3). Despite this, he is proud of his attention to detail when it comes to measuring his food intake, and is completely honest in responding to questions regarding this:

Jo: I got into it, sort of, being aware that that could be my downfall. This could be where people might...might catch me out, 'cause I knew that I...I wouldn't be able to, sort of, hold back in...in talking about it because it was the one thing that properly captured me. []and then they just dismissed it. And...and said that I was wrong....and then offered me a....a two-thousand three-hundred calorie meal plan and talked me through it. Erm....and so....I left and never went back. (Jo, 695-703)

Failing to allow for his level of activity as a growing teenage boy (to this day Jo works out regularly), they accuse him of lying about his calorie intake. Within the context of Jo's gendered discussion of the ED service, there is a sense that his therapists are not used to adjusting to the needs of male patients, and are instead applying female standards. Jo admits that his calorie counting was his area of weakness, saying that they "might catch me out". By this, he seems to be saying that this is where his therapists could have engaged him, using his self-knowledge and expertise to move him towards recovery. Instead, Jo loses interest and disengages when offered a meal plan well below the four-thousand calories he is consuming to maintain his active lifestyle (he readily admits that even this was probably inadequate).

Unlike Jo, Michael was at least weighed using male measures of BMI, but he questions their validity in his case:

Michael: Then, if you look at BMI, my weight was, was right in the middle [] of where it should have been on a BMI [] But apparently everyone said, "you looked so ill, you looked so thin". [] But I suppose....is my way of saying BMI....unreliable data.... (Michael, 73-79)

Michael is drawing attention to the fact that some physiques have a distorting effect on BMI scales, and that although technically not underweight, the consensus among those that knew him was that it looked as if he was, once again suggesting that the measures used were not sufficient to meet the needs of male patients.

Michael experiences male discrimination in group therapy, even though he recognises that his fellow group members do not mean to be unsupportive:

Michael:I was the only male. []they were quite sweet about it, and they meant in a nice way. I was the "honorary female" [laughs]. [] It was quite amusing as well, where you've got the women there, so, slating their partners about, "Men do this. Men do that.... Not YOU Michael. You're an honorary female so I don't mean you". (Michael, 709-805)

He is able to see the funny side of this, but also recognises that it further serves to deny his masculinity and invalidate him as a male with an ED. He also draws comparisons with racial discrimination:

Michael: *But [] going back to what I was saying about the, erm, er, the community race relations training [] you can imagine that person sitting there, "Oh no. I don't mean you. I mean all other black people". "Oh. So I'm not black?" (Michael, 805-809)*

Michael's experience serves to emphasise the problem with having individual males as members of otherwise all-female groups. Not only is there no other male to identify with, but he is also jokingly stripped of his masculinity to fit in with his fellow patients. As Michael admits to having struggled with his lack of conformance to male physical ideals (see Section 3.3.2), I wondered whether this had further undermined his self-concept.

Jack also experiences being the only male member of an otherwise all-female therapy group, and this had unexpected unhelpful consequences:

Jack: *....what I'm looking for in someone. [] It's someone to....idolise. Someone to worship. [] Someone to be with. And I have this hole in me that I need to fill that with a person. And if I, you know, I went to this group therapy with... you know, fifteen stunning, lonely girls, I was like, Oh my God! This is speed-dating. [] Erm...So that was meant to be helpful but it actually worked out as being probably not that helpful. [] And that frustrates me and that upsets me 'cause that's a regret, and regret you can't do anything about. (Jack, 899-914)*

For Jack, therapy becomes an opportunity for him to realise his desire for a long-term relationship, and his reflections on it reveal both self-awareness and vulnerability. There is an intensity and desire in his language. Jack's notions of relationships are not balanced: He wants to "idolise" and "worship" women. He is aware that this got in the way of his opportunity to benefit from group therapy, and is further frustrated because it becomes a source of regret to him. Being the only man in a therapy group for AN clearly demonstrates the low representation of men in treatment groups.

Peter's unwillingness to engage is linked directly to his gender, attributing it to being offered a female therapist:

Peter: *....a lot of my issues were to do with being a man. [] When I'm in therapy now [] ...If it's specifically for...male-oriented stuff [] I will only see a man. [...]. Because I need male identification. I am a man. [] I, er,*

absolutely need... [] to be understood by a man. I don't want to be with women. [] 'Cause I'm a man and I need that... at the moment, anyway, I've needed that male identification. (Peter, 844-861)

For him, gender is the defining problem with his therapist. Peter is underlining the importance of reinforcing his sense of male identity and the need for this to be shared by his therapist. It seems to be critical to him to explore his thoughts with someone who shares and understands his gender. In failing to engage with his female therapist, Peter seems to have discovered a strength and purpose which seems empowering, helping him to assert his identity.

When Clive did receive talking therapy, he found it to be a largely positive experience. Nevertheless, the focus was mainly on addressing his compensatory behaviours:

***Clive:** So now...so originally I was diagnosed with bulimia in my twenties...erm...and then I had treatment for that, and I gave up all the...compensatory stuff [] and I gained...a lot of weight. So I went from nine-an-a-half stone to double that. To eighteen-odd stone and...erm...And I was re-diagnosed with binge-eating disorder....which...I wasn't happy about. (Clive, 231-237)*

Clive is drawing attention to a peculiar anomaly associated with the way EDs are classified. Treating his compensatory behaviours causes Clive's weight to almost double as his binge eating is left unchecked. Consequently, Clive returns to his GP and finds himself diagnosed with an entirely new ED (and one with a name he is deeply unhappy with – see Section 3.4.2). Clive sees the absurdity of this:

***Clive:** It is funny that you...you go in with one, You go back and you say, "Right. This bit of me is actually well now. I'm not doing these dreadfully-punishing things to myself anymore [] and then [half laughing] you're handed another diagnosis. (Clive, 273-277)*

It doesn't make sense to Clive that treating one half of the symptoms of a condition, but not the other, can result in a new diagnosis, and I found myself comparing this with the transdiagnostic view of EDs.

Unlike Clive, Jo receives a diagnosis other than BN because shame prevents him from being candid with his therapists:

Jo: It was diagnosed as EDNOS, which to me read as, “you’re not good enough to be anorexic or bulimic”.....Erm. I never mentioned... I never brought up the...the...the bingeing episodes and compensatory behaviours.... (Jo, 271-273)

Having taken pride in his ED, Jo is frustrated by what he sees as the dismissive nature of the name EDNOS. As I was analysing his transcript, I found myself wondering what he would make of the term OSFED. Rather than curing one set of symptoms, withholding information about them leads to a different diagnosis.

Although not resulting from the treatment process, Peter has also experienced more than one ED and has strong views on how they are classified:

Peter: Overeating, undereating, restriction and anorexia and binge...and vomiting are not three separate entities. They are all the same to me. They are just part of the spectrum. (Peter, 285-287)

He has experienced a spectrum of EDs, including AN, BED and BN, but he dislikes the distinctions drawn between them, speaking instead in transdiagnostic terms (“They are all the same to me”). For Peter, the different ED classifications are part of a continuum, and he does not see the distinctions as meaningful or helpful.

Clive sums it up by saying:

Clive: We’re desperate to classify things and...categorise them. But the fact remains that it’s pretty rare that someone just presents with a [] perfectly clear diagnostic category where they’ve got all the features of one thing, [] and a lot of people kind of swing between different types of behaviours. (Clive, 286-290)

Both Clive and Peter are saying that practical experience points to ED sufferers moving between diagnostic categories. Clive seems to feel that this is something that is more about fulfilling the needs of academics and therapists to categorise than it is to do with meeting the needs of ED patients.

Setting aside his group experience, Jack is the only participant with predominately positive experiences of help-seeking, although the manner in which he benefits also transpires to be attributable to his otherness:

Jack: It was at actually the... [Conference A]. I was talking to one of the psychologists there and she was like.... It would have been like, “We’ve got a man. Who wants him?” sort of thing [...] and I think it does.... As much as I hate it. As much as it shouldn’t, it makes you stand out.

Jack already had huge self-awareness before approaching his GP, allowing him to own his condition. As someone who works as an ambassador for men with EDs, Jack has had the opportunity to discuss his treatment with others, and concludes that in his case, being male worked to his advantage. Not only was he accepted by the ED service but he also piqued the interest of potential therapists. Jack's dislike of standing out is in curious contrast to his chosen profession as an entertainer. I sense, however, that it is based on a desire for gender equality rather than an inherent shyness, although this may also be a factor given that he is someone who appears to feel more insecure offstage.

3.5.2 Subtheme 4b: “I was lucky. She had had a lot of experience” – Therapy fit for men.

Each of the participants was asked what they had found most beneficial from the therapy they had received. At the time of the interview, six participants had received some form of psychological therapy, and one (Gareth) was beginning to embark on the process. Luke was the only one not to have sought talking therapy, but had self-referred for private acupuncture treatment. This subtheme looks at the aspects of therapy that were of most benefit to them, with a view to gain insights on what therapy fit for men might look like.

Most participants seeking help seem to have had negative experiences of help-seeking, but only Jo was unable to find anything positive to say when asked what had been most beneficial:

Jo: It was....nothing really. (Jo, 648)

Given his experiences (see Section 3.4.1), this is not altogether surprising, and serves to demonstrate how alienating such negative experiences can be. The remaining participants were all able to find positive experiences of therapy, or had some idea of what it might be like to experience therapy that met their needs.

Jack emphasises the importance of being believed:

Jack: The first one was actually getting it. [] The first one was someone believes me. Someone actually believed. For the first time in my life I didn't feel like a fraud, 'cause I got that. (Jack, 616-619)

This passage conveys a powerful sense of being visible and accepted, countering his self-conceptions. It also conveys a sense of how little he expected to receive support, illustrated by his repeated use of the word “actually”, underlining his surprise.

Jack has benefitted from a person-centred approach, and seems to have gained a deeper understanding of himself and the origins of his difficulties. He describes his response to his therapist’s suggestion that they discuss his parents:

Jack: *I thought, really? We’re gonna do some Freudian shit? Let’s just move on. ‘Cause I didn’t realise there was a problem with the parents. And then she really persevered with it and at first, we both thought, well actually there’s nothing there. And then we [clicks fingers] kind of got down. We were like, woah! Shit! There is! Wow! (Jack, 640-645)*

Achieving insight seems to have been key to invoking a desire to change within Jack. At first his response to looking at his past is dismissive, but as patterns begin to emerge he becomes engaged and increasingly invested in his therapy. This seems to have engendered faith in his therapeutic relationship, allowing him to trust her vision of what life could be like for him:

Jack: *She’s [] given me a good insight into what life will be like after, and she’s....worked her tripes off to get me excited...to recover [] which no one else has ever done. [] And, yeah, being also.... Just being able to talk.*

What seems to have made it possible for Jack to talk is the effort expended by his therapist in engaging his interest in recovery. He talks of her “working her tripes off” and getting “excited”, both energising phrases. Having a vision for the future to work towards seems to have motivated Jack to continue, when at times he has found himself wondering whether it is worth the effort.

More recently, Jack has benefitted from undertaking some CBT with his therapist:

Jack: *....we’re trying to do CBT and the CBT....er....is... [] ‘Cause I requested that because she’s great, but she was, you know, she sort of tags me a little bit and was sort of like, “What sort of stuff would you like?” and I was sort of like I think I need to eat [] and it’s been a pain in the arse. So many worksheets, but it’s erm.... That’s actually been really useful for me.*

Through the work that he has done in therapy, Jack has come to accept that he must give up his AN and begin to eat. It is evident that this is a continuing struggle for him in

terms of the effort required and the frustration caused. His trust in his therapist seems to be key to this continuing commitment, demonstrated even when confronted with doubts. Despite his tendency to perform, there is no resorting to humour here. What comes across is a curious mixture of resolution and weariness.

Clive has also received person-centred therapy, and cites it as the most beneficial intervention that he has received:

***Clive:** I was in such a state when I went into therapy...about lots of stuff that the eating disorder was...had been helping contain [] that I needed to be able to do some person-centred stuff, really. (1272-1275)*

He recognises that his ED is a coping mechanism, and sees person-centred therapy as a necessary step (“I needed”) in dealing with the “stuff” that underlies his condition. There is a sense of desperation in this passage, and I wondered whether this “need” for person-centred therapy was also a need to be heard and validated:

***Clive:**it wasn't just about treating the eating disorder. It was about...trying to find a way to be at peace with myself and to learn...what...about what I was doing and why I was doing it. [] So now, [half laughing] interestingly, you try and get some brief focal treatment and it's really hard. [] “Oh that must be very difficult. You must want to talk about this stuff.” And I'm thinking, “No, just give me twelve weeks of CBT for goodness sake. (Clive, 1295-1302)*

Clive draws attention to the calming role of therapy, and the benefits of developing a deeper understanding of his behaviour and its causes. It becomes clear that Clive is juxtaposing person-centred therapy with CBT, and he seems to be saying that for him, the former was a necessary preparation for the latter. Although his account here is mainly positive, there is a sense of irritation surrounding the assumptions being made concerning his needs. Clive's treatment was part of a research project examining the benefits of long-term therapy for EDs rather than brief interventions, and I sense that Clive feels that there is a tendency to offer whatever interventions are in vogue rather than assessing his requirements in the context of the help he has already received.

Mark also identifies person-centred counselling as the most beneficial treatment he has received, although he also mentions participating in groupwork:

Mark: For example, for self-expression...speaking with [Mark's therapist], with the counselling, that was a good thing [] for self-expression. But for erm.... The reason I went to [Mark's ED group], for example, was...so I didn't feel as lonely, because I knew there was a group thing []but.... I think the counselling was probably the most effective in getting thoughts out and thinking about things. (Mark, 587-596)

He emphasises the importance of speaking about his experiences, and “getting thoughts out”, suggesting a process of externalisation which facilitates the reflective process. It also conveys a sense of needing to be heard. Michael highlights the issue of isolation, and the benefits of group work in tackling this. Being part of a group seems to engender a sense of belonging which bolsters the one-to-one work of his counselling.

For Peter, however, group work represents his most positive experience of therapy. He has accessed this through Overeaters' Anonymous, a twelve-step model based on group membership and support. Peter draws a parallel between twelve-step programmes and other types of group therapy:

Peter: When you have people who have a similar problem, who I can identify, that's where...I'm no longer on my own and powerless [] and twelve-step programmes, kinda like group therapy or peer support, they work in exactly the same concept. [] And that's ultimately what saved my life and brought me out of that behaviour, and brought me into...to reality, where I started to think, “Oh fucking hell! That...that person does exactly the same as me. You know. I thought I was the only person doing that.” (Peter, 799-807)

In the same way that he needs his therapist to be able to identify with him, Peter draws strength from sharing his experience of having an ED with other group members. There is a paradox in that by surrendering power he gains in strength, and this is amplified by the shared experience. The sharing brings him out of himself – He is no longer alone. It also brings him to what he calls “reality”. In seeing or hearing his behaviour represented in others he can gain perspective on it. Peter is unequivocal in his assessment of its importance. For him it has been life-saving.

When asked what he found most beneficial, Michael's response is unhesitating:

Michael: Group. [] Didn't take much thinking about, did it? [Laughs] (Michael, 1216-1218)

This appears surprising given the negative aspects of his experience as a member of an otherwise all-female group. The benefit Michael seems to have received from group therapy appears to match that of Peter in that there is a shared experience and belonging, even if it is at the cost of being an “honorary female” (see Section 3.4.1). It occurred to me that other than within his marriage, this group must have represented one of the few experiences in his life of (almost) unconditional positive regard.

For Michael, however, talking alone is not enough. He describes facing up to his ED within therapy as a particularly helpful experience:

Michael: *Forcing me to sit down and actually talk through.... Er, well, not talk through....admit....that....there was something I needed help with [] I've....I've always found it hard to ask for people's help and it always.... [] You know how you'll maybe go to someone to ask for help and the, erm, feeling you get from them is, "Oh, for God's sake! Can't you sort it out yourself? Why are you bothering me with.... [] What are you bothering me for?" (Michael, 1026-1033)*

His clarification is telling when he places the emphasis on admitting the need for help rather than just talking. It leads him into discussing help-seeking in general, and he admits that he finds this hard to do. I felt that the critical voice that he uses is that of his mother, recalling his sense of abandonment as a child after Michael's sister was born. Michael is slightly apologetic in saying this to me, as if he is concerned that I will respond critically to his thoughts.

Finally, although Luke opted for acupuncture following the death of a close friend as a result of a drug overdose, his experience is worth looking at as he credits it with beginning to open up and talk. Luke frequently refers to male reticence in his narrative, and in discussing the willingness of men to seek help he contrasts the reluctance of men to talk about their feelings when compared with women:

Luke: *When two men meet in a bar, you don't say, "Hey Harry. You've lost a few pounds.... Are your nails longer?" You say, "Fuckin' West Ham. Bunch of tossers. Bloody England – That Wales thing." (Luke, 676-678)*

Luke is using humour to display a deliberately distorted impression of both female and male discourse, but although it is trivial, he appears to be making the point that women connect on a personal level (noticing physical changes) whereas men do not (talking

about sport). When asked if he has had formal treatment, following a description of his acupuncture, he responds:

***Luke:** So, the quick answer is psychotherapy: probably yes. With a thundering load of needles at the end. (Luke, 670-671)*

Acupuncture seems to have freed him to talk to the extent that he has come to regard it as his own form of psychological therapy

Chapter 4: Discussion

4

4.1 Introduction

The literature review has demonstrated that much remains unknown about how men experience living with BN/BECB. This chapter will draw out some of the key findings from the data analysis, elaborating on them and relating them to the literature. The study itself will be evaluated, and suggestions made for future research. The implications for counselling psychology practice will be considered, before discussing epistemological and personal reflexivity.

4.2 Male lived experience of BECB

The following sections discuss the findings of the four main themes identified in Chapter 3, with reference to the literature.

4.2.1 Painful parenting experiences and their contribution to ED development

The findings of this study suggest that problematic parental interaction is perceived by participants to have a significant impact on the development and maintenance of their EDs, and that this can manifest itself in a variety of ways, including fear and control, deprivation and neglect, and the effect of parents' own relationships with food. What is also clear is that many participants experienced dysfunctional home environments, the cause of which cannot be attributed to their EDs. There was no reporting of childhood sexual abuse by participants, and uncontrolled physical violence did not seem to be a key issue. Jo was the only participant to experience this, although Gareth recalled corporal punishment until the age of six. There is little literature on men, but evidence exists in women of an increased risk of EDs when exposed to childhood punishment (Rorty, Yager, & Rossotto, 1995). Jo recalled the more extreme

circumstances of an alcoholic father prone to verbal and physical violence towards his family, although it is probably the verbal, physical and/or psychological abuse stemming from parental alcoholism that is the significant factor (Mintz, Kashubeck, & Tracy, 1995, Kent, Waller, & Dagnan, 1999; Waller, Corstorphine, & Mountford, 2007). Johnson et al. (2002) also found that there is a strong correlation between maladaptive paternal behaviour and ED development.

As suggested by Bruch (1962), and supported by the work of Williams et al. (1990), Dalgliesh et al. (2001), and Watt et al. (2002), control appeared to be a significant factor in the development of participants' EDs, with many reporting high levels of parental control, both benign and malign in nature. This seems to fit with the findings of Williams, Chamove, & Millar (1990) which identify external locus of control among ED sufferers, particularly with respect to the influence of parents and friends. The emotional control reported varied considerably in severity, ranging from Jack's mother's over-reaction to him not wearing a jumper, through to Michael's mother requiring him to prove his love for her. In line with the findings of Chassler (1997), maintaining family harmony appears to have been important to participants. It is difficult to put a value on the potential harm caused by such emotionally-controlling incidents. Personality factors also play a role, with some individuals being more resilient to such control and manipulation than others. Jack and Clive both grew up in loving homes, but still report feeling controlled by their parents. What is not clear is how much influence can be attributed to the controlling behaviour itself, and how much to inherent personality traits.

Subtheme 1b looked at deprivation and neglect by parents. Mark was the only participant growing up with an absentee parent. He cites his mother's absence in response to being asked how he accounts for the development of his ED, his experience seeming to support evidence that children from single-parent families are at a higher risk of developing EDs (Johnson, Cohen, Kasen, & Brook, 2002; Martínez-González, et al., 2003). Despite evidence that his father was not focussed on modelling healthy eating behaviours, (Wichstrom, 1995; Smolak, Levine, & Schermer, 1999), I sensed from Mark that his ED is more to do with not having emotional engagement from his mother, something that seems to be confirmed in

the way he talks about her (Bell, 1968; Maccoby & Martin, 1983; Carson & Parke, 1996; Boutelle, et al., 2009).

I wondered to what extent the power over others examined in subtheme 3c is a manifestation of behaviour learned from parents, given the degree to which many of them have been able to emotionally manage or deprive their children. All but one of the remaining participants talk about varying degrees of parental detachment, ranging from lack of interest to emotional withdrawal due to parental depression or illness. This seems to have had a particular impact on Mark and Gareth, with Mark's mother having been absent for most of his childhood, recalling parental absence in the published accounts of Craig (n.d.) and Sam (n.d.). There is also a sense of Michael's father not featuring much in his upbringing (he is curiously absent in Michael's narrative), and the love of his mother has been highly conditional.

Subtheme 1c looked at family issues with food and body image. The key points to emerge here were control of parents over the plating of food, a lack of understanding about healthy eating by parents, use of food as a means of emotional control, parental concerns over their own body image, and parents' own EDs. Clive and Mark were both served adult-sized portions of food as children, and it is possible that this encouraged overeating, as well as removing their sense of control (Rolls, Morris, & Roe, 2002; Savage, Fisher, & Birch, 2007). The majority of participants recall being overweight as children, and along with incidents of overeating, this mirrors the increased risk of BED found in women from such environments (Striegel-Moore, et al., 2005). Clive, Michael and Peter all mention varying degrees of parental preoccupation with food and weight, with food being used as a means of emotional and behavioural regulation. This supports evidence from Brown and Ogden (2004) suggesting that this is linked with higher levels of body dissatisfaction in children. They conclude that positive parenting is more beneficial to children's eating behaviour than dietary control.

Together, these three subthemes demonstrate a range of ways in which parents can contribute to childhood adversity. Johnson et al. (2002) have shown that children with parents exhibiting three or more maladaptive behaviours are three times as likely to develop EDs as those with parents not exhibiting such behaviours. There is also a strong likelihood that where

maladaptive behaviours are present in parents, this will add to the sense of shame already felt by individuals with EDs (Frank, 1991). Overall, there is a wide body of evidence to suggest that positive parenting, with a strong, emotionally-supportive relationship with the child, is inversely associated with preoccupations with weight, bulimia and feeling ineffective (Kenny & Hart, 1992). However, nearly all the literature has utilised mixed or female-only samples and studies are required to reveal if and how men are uniquely influenced by negative parenting.

4.2.2 Experiences of gender and identity

Gender and male identity also appear to have been key issues for participants, with Peter emphasising his need for a male therapist. Although this was not echoed by the other participants, it is noticeable that all those who did receive talking therapy did so predominantly from female practitioners. This is by no means unusual, with recent studies suggesting that 80% of mental health provision in the UK is delivered by women (Morison, Trigeorgis, & John, 2014). The key subthemes to emerge, however, were focussed on gender-role conflict and body dysmorphia, with participants not seeing themselves as living up to societal expectations of maleness.

An interesting feature of the analysis in Subtheme 2a is the degree of gender-role conflict (O'Neil, Helms, Gable, David, & Wrightsman, 1986) expressed by participants. The self-stigmatising expressed extends to the male gender itself, with Luke making disparaging comparisons with women in terms of physical beauty and articulacy, adherence to societal norms of masculinity (Thompson Jr & Pleck, 1986), and the appropriateness of having an ED as a male. Michael exemplifies this internalisation of societal stigma, with “mummy’s little soldier” standing in for “boys don’t cry” (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Although he is the most overt in his articulation of societal (and personal) gender expectations, perceived failure to live up to these is present in many participant narratives.

Both Michael’s fears of being seen as gay, and Luke’s references to Kenny Everett, seem to be linking failure to fulfil masculine stereotypes with homosexuality. In both instances, the fear seems primarily to be not being seen as masculine, rather than being perceived as

gay per se, although their discourse suggests confusion between gender and sexuality (APA, 2015). Curiously, Michael's assertion of masculine ideals is also echoed by gay participants, with both Peter and Clive describing in negative terms what they see as feminine aspects of their physique. This seems to endorse the gender-role conflict findings of Sánchez et al. (2010), and also those of Blashill and Vander Wal (2009) suggesting that body-dissatisfaction may be a significant mediating factor.

With the exception of Jo, who identifies as non-binary, there appears to be a strong tendency among the candidates towards being gender normative, demonstrating that this is independent of sexual orientation. Numerous studies have indicated homosexuality is a risk factor for EDs in men (Silberstein, Mishkind, Striegel-Moore, Timko, & Rodin, 1989; Russell & Keel, 2002; Yelland & Tiggemann, 2003), although the evidence is less marked for women. Four of the eight participants identified as gay, with one currently seeing himself as heterosexual but having previously questioned his sexuality. Sexuality seems to have been a factor in developing tendencies to withdraw (see Sections 3.4.1 and 4.2.3).

Peter and Jack's talk of emasculation and androgeneity in describing their disorientation over their masculinity conveys their experience of a gender void rather than a centre ground, concepts that have also arisen in the work of Spyrou (2014). Jo echoes this in his description of his loss of gender orientation. For him, it led to a questioning of both his gender and his sexuality, although he has now embraced this middle ground as being on a gender continuum. Jo and Jack both attribute their gender identity conflict to hormone disruption. Jack's comments concerning the appropriation of aspects of maleness supports the notion that increasingly it is only through their bodies that men can differentiate themselves from women (Leit, Pope, & Gray, 2001).

Subtheme 2b looked at how men experience their bodies, particularly during puberty and early adulthood. Several participants mentioned a propensity to put on weight, resulting in feelings of shame and self-consciousness. Bullying also featured among these narratives, supporting the experience of others who have written about their EDs, including Russell Brand (Brand, 2008; Cuban, 2013; Andrew, n.d.). The self-isolation described by Peter and Gareth

(see Sections 3.4.1 and 4.2.3) seems to support the theory that withdrawal is a protective mechanism against bullying behaviour (Markham, 2013).

Contrary to O'Dea and Abraham (1999), bodily changes and weight gain occurring in puberty were cited by several participants as a contributory factor in the development of their ED. Only Clive mentioned early-onset of puberty, however, and it is possible that this and the hormonal changes explored by Zehr et al. (2004) may have played a role in his ED development (Kaltiala-Heino, Rimpela, Rissanen, & Rantanen, 2001). I sensed, however, that shame was a bigger factor, and that felt by Clive during adolescence seems different to his shame in adulthood. The former seems to be associated with a discord between developing a man's body while wanting to remain a child, as well as not wanting to stand out among his peers. The latter seems to be about not fitting in with a societal image of male physical perfection.

Participants frequently spoke of their bodies in feminine terms, describing themselves as rounded, not fitting to a masculine ideal, supporting the observations of Halliwell (2002) concerning actual/ideal-self discrepancy and the link to emotional eating. None cited children's toys as a contributory factor (Pope, et al., 1999; Leit, Pope, & Gray, 2001; Baghurst, et al. 2006), but some, such as Clive, Gareth, Peter and Mark, appear to have formed a sense of societal masculine ideals before adolescence. The pressure to fulfil this masculine ideal was summed up by Michael who carries with him a clear sense of what society looks for in men, be it rugby-player ruggedness or film-star sleekness.

4.2.3 The need for, and loss of, power and control

Subtheme 3a looked at the way that participants felt themselves to be invisible, with Jo admitting to using his ED as a means of getting noticed, to be the best at something. A key issue in this theme is of men being invisible because they do not fit criteria laid down by society or, more particularly, the medical profession (it seems that gay is fine, but men with EDs should not be heterosexual or transgender). Jo experienced help-seeking as a tick-box exercise, with the assessor not even seeing that the person in front of him was a man rather than a woman.

His experience echoes that described by Warburton (2015), demonstrating that EDs in men are often not taken seriously. Jo appears to have missed appointments as a way of testing his visibility, but was never followed up. Participants such as Peter talk of feeling like outsiders, associating with other marginalised groups (those not picked for games) with the ED part of a vicious circle of being marginalised and self-marginalising. This conforms to Markham's detachment response as an alternative to trying to conform to societal ideals (Markham, 2013). The net result of this is a lack of self-acceptance and self-validation, and ultimately loneliness. As Levine (2012) has noted, this can fuel ED symptoms and, with BN in particular, heightened risk of suicide (Crow, et al., 2009), a possible outcome that Michael alludes to.

Another feature of this is the loss of emotional control, explored in Subtheme 3b. The overwhelming emotion discussed by participants is shame (Poole, 2014). Although Jo talks about loss of control over his moods, what is worse is the shame of being compared to his violent and abusive father. The use of emotional eating as a coping mechanism (Foran, 2015) is ultimately experienced as counterproductive because of the intense feelings of shame associated with over-eating. Again, a vicious circle is established when further over-eating occurs in order to self-soothe the feelings of revulsion resulting from the initial binge. Shame is also associated with bodily changes, particularly following puberty (Zehr, Culbert, Sisk, & Klump, 2004). Much of this links to notions of gender identity (Ålgars, Alanko, Santtila, & Sandnabba, 2012) and the ways in which participants feel that they do not meet individual or societal expectations of masculinity.

Sometimes this self-isolation and shame can lead to a recapturing of power and control, something explored in Subtheme 3c. The potency of holding a secret or being able to wield power over others must seem very appealing to a group feeling so marginalised and with a strong external locus of control (Bruch, 1962; Williams, Chamove, & Millar, 1990). Several participants discussed this power of secrecy, with Jo particularly enjoying being able to fool his practitioner. Both Michael and Jo talk in terms of "winning", which seems an odd concept in that because of their secrecy, it is often a game that others don't know that they are playing. The need for this is indicative of the lack of control they seem to have felt elsewhere in their

lives. Bingeing becomes something that they can succeed at (Jeppson, Richards, Hardman, & Granley, 2003). For Jack, this control appears to have assumed a sense of omniscience, with him ultimately holding control over his own life and death.

Eventually, however, the control offered by their ED is seen to be illusory, and itself becomes a reason for self-punishment. The use of emotional eating in adolescence, resulting in weight gain and associated name-calling and bullying, is perceived by some participants as a lack of self-discipline. Jo describes being so out of control that cutting himself on tins would not stop him from eating. He even talks of losing control of the medication he used to take to help himself feel in control. Mark talks about his BN as if he is in control of it, but then admits to losing control of this cycle. It is Michael who voices the illusion of believing himself to be in control of his ED and then realising it is controlling him, something that even manifests itself in a loss of physical control. For Peter and Luke, the comparisons are with addiction, with the ED being seen as an external force beyond individual control. It is possible that the addiction model (Brisman & Siegel, 1984; Gordon, 1990) plays an important maintaining factor in BN, making it harder to break out of a cycle of behaviour that is potentially supported by so many other factors.

4.2.4 Experiences of help seeking

The sense of invisibility experienced by many participants appears to manifest itself in a sense of “otherness” when help-seeking. It is as if because they do not fit the criteria assumed by the charity or the ED service (often because these are formulated on women’s needs), they do not really exist. This is most clearly demonstrated by Clive’s conversation with a charity worker telling him that they do not normally speak to men (“Okay, but you’re speaking to one now” - Clive, 1645). It is as if he is a nobody on the phone. This sense of otherness manifests itself in guidelines and literature that do not acknowledge the existence of men or, if they do, only gay men. For heterosexuals or transgendered people there is insufficient acknowledgement of their needs. Where changes have taken place, they appear to be adaptations of services or resources designed for women, rather than a bottom-up approach

for men. The need for a charity such as Men Get Eating Disorders Too is a clear example of the problem. The word “Too” in the name serves as a plaintive reminder. For men such as Peter, it is as important that they should have access to a male therapist as it is for a woman to be able to see a female therapist.

Otherness also manifests itself in diagnostic criteria and treatment protocols that have been adapted rather than designed for men, failing to acknowledge the different emphasis on physique over weight in male AN patients. In terms of treatment, it leads to men finding themselves in overwhelmingly-female groups where they either feel isolated or have their gender identity further undermined by being accepted as honorary women (or, as with Jack, see it as an opportunity for speed dating!). The consequence of all this is that by treating men as other (aliens) it simply reinforces their sense of alienation. This is likely to have a direct bearing on client engagement in therapy. In effect, the ED service becomes another manifestation of the playground bully, with male ED sufferers adopting the same distancing behaviour as a form of self-protection.

There is also a sense of otherness associated with the terminology used (although this is non-gendered). The term EDNOS (now superseded by OSFED) can add to an ED sufferer’s sense of failure by not being good enough to fulfil the criteria of a recognised ED. BED is even worse as, contrary to terms such as AN or BN, it eschews a Greek-derived name and opts for one that is highly descriptive and shame-inducing. Many participants have experienced other EDs, including AN and BED (Michael still has symptoms of rumination disorder), and this supports the findings of Fairburn et al. (2008) concerning diagnostic crossover. Clive has highlighted the absurdity of a diagnostic and treatment approach where the treatment of one set of symptoms while leaving another untreated, can result in a new diagnosis. This appears to have translated into a reluctance to seek help from some participants, with Peter turning his back on the NHS, Gareth only just beginning to engage and Luke turning to acupuncture as the only therapy he has tried. Gareth’s delay may be linked to a traditional male reluctance in help-seeking (Yousaf, Grunfeld, & Hunter, 2015), but there is also strong alienation resulting from unhelpful therapeutic interventions.

The picture is not all bleak, however, with Subtheme 4b revealing some helpful aspects of therapy that can be carried forward in the development of ED treatment fit for men. The opportunity for self-expression seems to be of key importance, with Clive, Jack and Mark all acknowledging the importance of this. Clive and Jack specifically named person-centred therapy as being helpful (although Jack's therapy also appears to have integrated some psychodynamic aspects in its exploration of his childhood and family), and it is likely that the focus of unconditional positive regard and acceptance was key to getting them to engage. It is interesting to note that, contrary to Peter's preference for a male therapist, Clive and Jack were both able to form a strong therapeutic alliance with a woman, endorsing the observation of De Beer and Wren (2012) that it is the recognition of their maleness that is more important than the sex of the therapist. It is possible, however, that the mere absence of choice of therapist gender could be perceived as an example of such lack of recognition.

Although there were negative aspects of group therapy, the opportunity to discuss experiences with others seems to have been beneficial, as does a sense of belonging (even if achieved with "honorary female" status). There is an obvious danger, however, of men feeling isolated within predominantly female therapy groups (Robinson, Mountford, & Sperlinger, 2013), as well as the potential for the presence of men to impact adversely on women's treatment if single-sex groups give way to mixed. Ideally, ED services need to achieve critical mass for male treatment to be able to sustain all-male groups. It should also be noted that some participants have achieved successful outcomes by looking beyond the NHS. The twelve-step model seems to have been of particular benefit to Peter, perhaps because instead of fighting with the issue of control, he is able to relinquish it in the face of acceptance of a higher power. This raises the important issue of acceptance, with the use of Acceptance and Commitment Therapy a possible treatment approach for managing shame. There should also be an approach which acknowledges anything that helps, even if that includes psychotherapy with "a thundering load of needles at the end" (Luke, 671).

4.3 Evaluation of the study

The aim of this study was to explore men's lived experience of BECB. In doing so, it aimed to add to what is currently a meagre range of experiential studies based on male study groups, with the intention of drawing attention to particular risk factors in the development of their EDs, and the needs of men with reference to service provision and therapeutic approaches. The use of IPA has enabled me largely to achieve these objectives, with some reservations that I will go on to explore in the following subsections.

4.3.1 Strengths and Limitations and Suggestions for Future Research

The strongest element of this study must be credited to the participants themselves. Their accounts form a powerful body of material that it is barely possible to do justice to within this thesis. For every theme included there was another that had to be set aside for lack of space. All the participants considered their ED to be a problem, and there was an obvious willingness to be as candid as possible, with the exception of Peter's reluctance to say more about his upbringing, where it seems the memories remain too raw. Foran has reflected on the role her gender had to play in the success of her study of emotional eating in men, and I have wondered whether being of the same sex as my participants was a help or a hindrance. I am inclined to believe the former as there were moments of candour, such as from Michael, where a fear of being seen as politically incorrect may have prevented him from articulating thoughts for fear of being misunderstood or misjudged.

Among the limitations of the study, the first must be directed towards recruitment. The difficulty in finding participants placed a heavy reliance on one source, and as such means that there was a large body of potential interviewees that was untapped. Those willing to be interviewed were probably more tolerant of shame than others who did not volunteer to participate. It should also be noted that the recruitment criteria were broad in age range. An effect of this is that some participants describe experiences that took place decades ago while for others they are much more recent, and in some cases ongoing. The variety of experiences expressed suggest that, although in many respects heterogeneous, more heterogeneity could

have been achieved with a narrower focus for the study. Luke, in particular, is in some respects an outlier, and there is probably scope for further research on particular BN subgroups, such as former elite athletes, sportsmen needing to adhere to weight limits (such as boxers or jockeys), male models and actors.

An issue with the study that runs counter to the argument just made concerns the choice of focus on BN. It was clear that Jack identified probably as having AN, despite at one time having met BN diagnostic criteria based on self-report. Given that most participants appear to have experienced more than one ED, I found myself questioning the merit of excluding men with other EDs. This is because with hindsight, when answering questions there were times they were not always specifically relating their answers to BN.

One aspect of the study that began to manifest itself was the assumptions made in the use of the term male. This became apparent when I attended a conference organised by Men Get Eating Disorders Too, during which the term “men” became the subject of slightly heated discussion. I realised that as well as having men who were born biologically male but who were in the process of trans-gendering, the conference also included men who were born female but had completed gender reassignment. As I was primarily interested in adding to the meagre body of literature on men, I decided to restrict my definition to men who were born biologically male and had not undertaken gender reassignment. It did, however, alert me to my own restrictive thinking on the subject and to the need for studies directed towards understanding the experiences and needs of the trans-gender and non-binary communities.

A final problem with the study was the comparative lack of literature relevant to the study group. This resulted in an over-reliance on women-only studies, or on behaviours seen in studies of other EDs, such as BED or AN. Given that many of the participants had also experienced episodes of these two other disorders, the second of these issues may be less of a problem. Nevertheless, it does highlight the need for further studies using mixed or all-male samples.

In terms of other areas for future research, the potential use of person-centred therapy to facilitate initial engagement of men and allow self-expression in the early stages of therapy

would benefit from further exploration. The use of person-centred therapy in male ED treatment was not a central focus of this study and would benefit from more targeted research, both from the perspective of patients and practitioners.

4.3.2 Ensuring standards of rigour and credibility

In line with the methodology and Smith et al.'s (2009) recommendations, quality was addressed using Yardley's (2008) criteria. Adherence to these criteria are summarised below:

4.3.2.1 Sensitivity to context

Having experienced at first hand the effects of EDs, and having a strong desire to understand the topic more fully, I was already pre-disposed to be sensitive to the context of this study. The person-centred core, achieved in my training as a counselling psychologist and my earlier training as a bereavement volunteer, moved me towards the core conditions of empathy, congruence and unconditional positive regard in my interviews, enabling me to develop a strong sense of trust, and at times relational depth, with participants (Rogers, 1961; Mearns & Cooper, 2005). This resulted in the collection of rich datasets, enabling proper depth of analysis. This sensitivity can also be seen in the analytical process, with care taken to allow themes to emerge from the data rather than be imposed from above. Thirdly, I hope it can be seen in the writing of this thesis, with sufficient use of verbatim quotes employed to support the phenomena and interpretations presented. Finally, sensitivity has been shown in the background reading undertaken, and the synthesis of this presented in the introductory chapter.

4.3.2.2 Commitment and rigour

Commitment and rigour has been demonstrated from the outset in the design and recruitment processes used and the methodology adopted. The sample met the criteria for the study and was representative of the research question posed, demonstrating sufficient homogeneity (see Section 4.3.2.1). The interview adhered to the semi-structured interview schedule, with use of supplementary questions to elicit further information and ensure sufficient

richness of material. The analysis was also conducted systematically and with rigour, adhering to the methodology established by Smith et al. (Smith, Flowers, & Larkin, 2009). The number of themes identified was proportionate to the sample size and the depth and richness of the data, with strong, representative quotes used to illustrate them.

4.3.2.3 Transparency and coherence

Transparency has been observed throughout, each stage of the data collection being described in the methodology, with examples given of the recruitment materials used (Appendixes B and C), the pre-interview questionnaire (Appendix D), the study information sheet (Appendix E), consent form (Appendix F), debriefing sheet (Appendix G), and the semi-structured interview schedule (Appendix A) provided for inspection. Similar transparency can be seen in the data analysis, with examples of each stage in the process being shown, including the post-interview memo (Appendix H), pre-analysis transcription (Appendix I), initial noting (Appendix J), emergent themes (Appendix K), theme clusters (Appendix L), and the use of NVivo for managing the development of the master themes, with dynamic linking (Appendix M). Proof of City, University of London, ethics clearance is also demonstrated (Appendix N).

Efforts have also been made to demonstrate the coherence of the analysis presented by ensuring progression of the data in each subtheme, attempting to link each point to allow the theme to develop clearly and comprehensibly. Efforts have also been made to show the variations in this data and to analyse contradictions in a way that is consistent with the standards used for the rest of the data. The choice of the topic also demonstrates coherence, aiming to add to the currently meagre research available about male lived-experience of BECBs. Effort has been made to ensure that the data presented is truly experiential, and I have also tried to emphasise the interpretative nature of the work throughout the narrative.

4.3.2.4 Impact and importance

The research findings arising from this study give new insights into the experience of men with EDs, and BECB/BN in particular. The existing body of literature is too narrow and needs to be enlarged to ensure that treatment protocols for men are developed from the ground

up in an evidence-based manner, rather than being adaptations of pre-existing material developed on the basis of information derived primarily from female-only populations. The impact for the practice of counselling psychology is clearly addressed and areas for future investigation identified.

4.4 Implications for counselling psychology practice

The findings of this study contain a number of implications for counselling psychology practice, some of which are gendered whilst others are equally applicable to the treatment of women and non-binary clients. Some of the worst treatment experiences described in this thesis are also the most recent, so although there is a much greater awareness of the requirements of male ED patients, there is still a need to make better provision for men in ED services. Rather than thinking about how services, diagnostic tools and treatment models can be adapted for men, there is a need to envisage what treatment fit for men might look like. This can then be compared to the models used for women to see what can be borrowed or adapted. There is much evidence that men and women experience EDs in similar ways, but at the very least there needs to be a more effective approach to engagement in therapy to ensure that men feel included and that their masculinity is recognised and respected. This needs to be the “gender-sensitive service” called for by De Beer and Wren (2012, p. 433), and must be proactive in seeking out the men who are not currently presenting for treatment.

This, in turn, leads to the question of the importance of the therapist’s gender. Fairburn, Cooper and Shafran (2008, p. 29) make several observations on the importance of therapist gender, observing that female therapists have “certain advantages” given that most of their clients are women. It is likely that twenty-five percent of ED sufferers are male and evidence suggests that men constitute between fifteen and twenty-five percent of those providing front-line psychological service delivery (Morison, Trigeorgis, & John, 2014). No figures are available for staff gender within specialist eating disorder services, and few websites list their staff. Of two that did, all seven psychiatrists, psychologists and psychotherapists at the Maudsley Hospital were female (Maudsley, 2017), and thirty-three (91.7%) of thirty-six at Cotswold

House (incorporating five services within Oxfordshire, Buckinghamshire and Wiltshire - (Cotswold House, 2017)). Further research is required to assess the full extent of this problem, but while women are highly likely to be able to work with a same-sex therapist, the probability for a man is very small indeed. As well as obtaining a clear picture of the gender balance of front-line staff within NHS ED services, it would be interesting to know whether male mental-health practitioners are themselves displaying a bias against working with a “women’s” condition. There is a clear need to attract more men to help deliver frontline ED treatment.

Fairburn, Cooper, & Shafran (2008) also state that the physical appearance of the therapist has little relevance if they are of a different age or gender, although they might lose credibility if they are themselves obese. It is possible, however, that there may be an effect if the therapist is of a similar age to a significant carer, be it the mother, father or other relative. The resemblance may not necessarily be physical, but given the findings of this thesis that parent-figures can have an impact on ED development, it is possible that such resemblances may impact on engagement and the development of the therapeutic alliance.

Of particular importance for counselling psychology is the emphasis that some participants placed on person-centred therapy. Counselling psychologists are uniquely placed through their training to be able to offer this, as well as CBT or psychodynamic approaches to the treatment of EDs. The person-centred approach seems to be important in allowing men the opportunity for self-expression, and seems to have been beneficial in facilitating engagement before other therapeutic models, such as CBT, are employed.

A more general issue concerns the use of terminology such as “Binge-Eating Disorder”. Shame seems to play a significant role in the development and maintenance of EDs, and by using this term with patients, professionals may be contributing to their lack of self-worth. The words “binge” and “disorder” are judgemental in a way bulimia nervosa is not. A solution might be to adopt a more transdiagnostic approach to EDs, possibly employing a more inclusive phrase, such as “eating dysregulation”. This might facilitate a more transdiagnostic approach which would have the benefit of addressing the problem of moving a client from one eating disorder to another simply by addressing one cluster of symptoms (compensatory behaviours)

without dealing with the overeating (as demonstrated with Clive.) It would also deal with the sense of “otherness” embodied in the term “OSFED”.

4.5 Epistemological and methodological reflexivity

The constructivist-interpretivist epistemological stance (Ponterotto, 2005) adopted within this study has informed my implementation of the methodology throughout the research process. The study is comprised of eight individual narratives, all bringing their own experience and interpretation of the topic of study, and these have been further interpreted and mediated by myself, not only during analysis and write-up, but also during the planning process and the conducting of the interviews themselves. This thesis is, therefore, genuinely a co-construction.

Reflexivity has formed a large part of this process, not least because of the circumstances described in Section 4.6. As a therapist, I work primarily from a person-centred and cognitive-behavioural perspective. My congruence requires me to be present, but I try to be led by my clients. I assume that what my clients tell me is true, whilst understanding that there may be reasons why this is not the case, or that this truth may only be partial. Their experience of this constructed “truth” is enormously revealing, and I endeavour to encourage my clients to lead in this process of reflection and interpretation, seeing myself as a catalyst in this process. In a similar way, I have been present in these interviews, but again primarily as a catalyst in an attempt to elicit greater depth and understanding of their experiences.

In terms of my methodological approach, I feel that my choice of IPA has enabled me to achieve a greater level of understanding of individual lived experience, and has opened my eyes to a breadth that is easily lost in quantitative studies. As a group, men with EDs have been woefully understudied, and it seems to me to be important to give greater attention to their experience before developing new theories which will, inevitably, build substantially on a literature base that is over-reliant on female studies. As a result, I feel more inclined to use this study as a springboard to further phenomenological studies, as so many additional lines of inquiry suggest themselves. Reviewing the methodology, I have found Smith, Flowers and Larkin’s (2009) model of IPA to be flexible and responsive to the topic, whilst at the same time

laying down a framework that can be adhered to, is justifiable, and produces meaningful results. Although mediated by my own interpretations, I hope that the voices of my participants can be heard and have been faithfully represented.

4.6 Personal reflexivity

Towards the end of February 2015 my eldest daughter Emily began to show signs of hyper-manic behaviour. Although she was apparently happy, I was very concerned about her increasingly erratic behaviour. On 24 February, I consulted a friend who is a retired psychiatrist, and later spoke at length to Emily's GP, although understanding that this conversation would inevitably be constrained by patient confidentiality. Whilst sharing my concern, the GP felt that Emily was not in imminent danger, which at the time I believed to be true. I spent the evening talking with Emily, discussing her plans for the coming year, once she had taken her university finals. I then wished her goodnight before going to bed. Shortly after midnight my youngest daughter heard the front door open and close. The following morning my coat was found on the bonnet of a car by the river in West Oxford. Emily had left her wallet and mobile phone at home and, without a coat, was lightly clothed for the sub-zero temperatures. Her body was recovered from the Isis nearly five weeks later. She was twenty-two-years old.

These events took place just after I had conducted my first interview with Michael, and shortly before my second interview with Gareth was scheduled to take place. I was certain from the outset that Emily was dead. In retrospect, I think that I was in a state of shock in the following weeks, although benefitting from the wonderful support of my fellow trainee counselling psychologists and tutors. I gave serious consideration to abandoning this study, but had I done so I think it is unlikely that I would have had the energy to repeat the process of identifying a new thesis topic and pressing forward. With a family to support, there was an imperative for me to complete my doctorate and, more strongly than ever, I wanted to develop a greater understanding of the psychological pressures that Emily had been under. I met with Gareth as planned, and the remaining interviews were completed approximately five months

later. Listening back to the tapes, I am struck by how calm and empathetic I sounded. I remember, at the time, being able to immerse myself entirely within their experience.

The same cannot be said for the process of transcription and coding, which I found profoundly painful. Hearing the accounts of my participants' personal distress made me wonder about the distress of my daughter, that I had either not seen or not properly understood. It was also impossible to ignore the emerging theme of parenting and its contribution to ED development. In listening to the courageous accounts given in each interview, it was inevitable that I should come to question my own parenting and culpability, however much I was able to distance myself from the more extreme events experienced by some of my interviewees. This presented a challenge during the coding process in that I had to avoid being overly harsh on my interpretation of parental interactions (self-punishment) or overly lenient (letting myself off the hook).

Having the opportunity to share the experiences of my participants has been life-changing for me. I was deeply moved by their courage and resilience in the face of a powerfully-debilitating condition, not to mention the life-events leading to using their ED as a means of coping. In particular, the participants' willingness to open up to a stranger and share such intimate details of their lives, especially given the shame that they readily admitted to feeling, was profoundly humbling. To them I owe an enormous debt of gratitude, and to Emily too. Perhaps most of all I have learned to challenge my pride. There is so much that I didn't know about Emily, and so much that my participants hid from others. It has made me value even more every small detail that my clients find the courage to share with me. It has also taught me the importance and therapeutic power of forgiveness, to others and most importantly to myself.

In my practice, I have also directly benefitted from the challenging of my naively-binary assumptions concerning gender and sexuality. Early in the data-collection process I was fortunate to attend a conference organised by Men Get Eating Disorders Too. As I listened to the speakers and the contributions from the floor, I realised that describing my subject group as "male" was insufficient. Did I mean individuals identifying as male or born biologically male?

If the latter, what if they had partially or fully transgendered and were now living as female? What about those born female who had partially or fully transgendered into becoming male? As stated in the methodology, I decided to focus my study on those born male and who had not undertaken any gender reassignment, while not necessarily identifying as male. This was because my primary focus was on male experience rather than transgender experience.

I am enormously grateful for the candid insights participants gave me into uncertainty in their gender identity and sexual orientation. This has equipped me in my practice to feel far more connected with clients experiencing similar dysphoria. In my personal life, I treasure my remaining living daughter and do my best to give her the space she needs to live and grow, while knowing that the opportunities to spend time with her today might not be there tomorrow.

4.7 Conclusion

BN, like all EDs, has traditionally been associated with women, and although this is no longer the case within the research community, there remains a lack of research featuring male participants. This study has provided new insights into male lived experience of BECB. It has highlighted the increased sense of shame experienced by men with this ED, many of whom perceive EDs as a female problem. A unique difference between men and women in EDs is the role of gender identity, with male body dysphoria frequently being associated with feeling feminine. It has highlighted that “gender-neutral” ED services are failing in their aim because ED treatment is built upon adaptations of female diagnostic and treatment models, and therefore has a built-in gender bias. It has shown that the services currently offered can play a role in demotivating men to remain engaged, or even seek treatment in the first place. While many of the treatment protocols may be readily adaptable, or equally applicable to men, different approaches are needed to encourage men to come forward and engage in the first place. This will mean providing service environments that are more male-friendly.

I sincerely hope that many of the issues identified in this study will prove to be transitory in their nature. If the issue of male EDs becomes more widely recognised and accepted, it is to be hoped that increasing numbers of men will come forward for treatment. This will, in itself,

help to make ED services more male-friendly as men will begin to feel less isolated. An increased interest by male practitioners in working with EDs will also be beneficial, providing a greater opportunity for male patients to request a same-sex therapist, as women are currently able to do. I hope to play my part in this by building on this learning experience in my professional practice. I feel deeply honoured to have been able to elicit the trust of the participants in this study, and would like my learning to benefit others experiencing their own challenges with EDs. I feel that counselling psychology, with its humanistic underpinnings, has a key role to play in this. In the years to come, I look forward to seeing more ED services providing therapy that is fit for men.

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Section B:

Case study

Using CBT-E with an underweight client

Matthew Stiff

Supervised by Dr Courtney Raspin

REDACTED

**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.**

Section C: Journal Article

Experiences of power and control for men with binge eating and compensatory behaviours

Matthew J.H. Stiff & Courtney G. Raspin

**The full text of this article has been
removed for copyright reasons**

Appendixes

Appendix A: Semi-structured interview schedule

1. When agreeing to take part in this study you said that you have, at times, eaten unusually large amounts of food within a short period of time, followed by.... (use examples of compensatory behaviour taken from the participant's questionnaire).

How would you describe this pattern of eating and compensating?

- a. Do you have a name for it?
 - b. Do you regard it as a problem?
2. How do you account for the development of your [eating disorder] (and/or any associated eating disorders – Use the interviewee's own name/language for their eating disorder wherever possible)?

What were the impacts (if any) of

- a. Your family
 - b. Where you lived
 - c. Your friends
 - d. Society and culture
3. Did/does your [eating disorder] fulfil a specific purpose for you? If so, what?
 4. Have you received any formal treatment (either medical or psychological) for your [eating disorder]?

If yes,

- a. What treatments were of most benefit?
 - b. What were of least benefit?
 - c. If not, why not?
5. How would you describe the current state of your [eating disorder] (e.g. no remission, partial remission, full remission – Participants should be allowed to

Appendix A: Semi-structured interview schedule

choose their own words. It will be important to explore the meanings that these words have for them).

6. What changes (if any) have you made to your life in response to your [eating disorder]?
 - a. What brought about these changes?
 - b. Which changes (if any) have been most helpful?
 - c. Have any of these changes proven to be unhelpful?
 - d. What have you found easiest to change?
 - e. What has been hardest?
 - f. Have you been able to maintain these changes? If so, how?
 - g. Are there any changes you have been unable to make? If so, what are these and why do you think that is?
7. Has your [eating disorder] had a lasting impact on your life? If so, what form has this taken?

Is there anything else that you would like to add?

Appendix B: Study advert



**Department of Psychology
City University London**

MALE PARTICIPANTS NEEDED FOR RESEARCH INTO MEN'S EXPERIENCE OF BINGE-EATING AND COMPENSATORY BEHAVIOUR

Have you at any time (now or in the past) eaten large amounts of food in one go and then gone to the gym to try to burn it off? Do/did you try to compensate for your eating in other ways, such as making yourself sick, using laxatives/other medications or dieting? If so, would you be willing to share your experience with us?

What is involved?

Volunteers will be asked to complete a questionnaire, prior to participating in an interview exploring your experience of living with binge-eating and compensatory behaviour.

Your participation will involve between 1 and 2 sessions of approximately 75 minutes each. These sessions will be organised at a venue convenient to you.

Will it be confidential?

Yes. No identifying information will be included in the outcomes from this research.

How will I benefit?

In appreciation of your time, you will receive an honorarium of £40 and reimbursement of agreed travel expenses. You will also have an opportunity to share your thoughts and feelings on eating problems and how men experiencing binge-eating and compensatory behaviour can best be supported.

How do I take part?

For more information about this study, or to take part, please contact:

Dr Matthew Stiff (Researcher),
Psychology Department

(t) [REDACTED]
(e) [REDACTED]

Dr Courtney Raspin (Supervisor),
Psychology Department

(t) [REDACTED]
(e) [REDACTED]

This study has been reviewed by, and received ethics clearance through the Psychology Department 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 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

Appendix C: Web summary advert

MGEDT
men get eating disorders too

Supporting men with eating disorders, carers and families to get their voices heard

home / about us / services / information / peer support / stories / latest / links / get involved / conference / training / contact /

GET INVOLVED

- Be an MGEDT Champion
- Be an MGEDT Ambassador
- Fundraise for us
- Media case study requests
- Research participation requests**
- Eating Disorders Awareness Week 2016

Research participation requests

If you would like any research participation requests posted here please email eam@mengeteditsite.co.uk

Would you be in a position to share your experience to improve knowledge and understanding of eating disorders in men? If you are a male with an experience of eating disorders and would like to tell your story to help support other men in similar situations please get in touch.

We are equally keen to hear from carers, parents, siblings and partners of men with an experience of eating disorders.

Research participation requests

The lived experience of men suffering from binge eating and compensatory behaviour – City University London is looking for male participants for a research study.

Have you at any time (now or in the past) eaten large amounts of food in one go and then gone to the gym to try to burn it off? Do/did you try to compensate for your eating in other ways, such as making yourself sick, using laxatives/other medications or dieting? If so, would you be willing to share your experience with us?

Bulimia Nervosa (BN) is a serious eating disorder affecting between 0.5% and 1.4% of adolescent males. Because men often do not seek help with binge eating and compensatory behaviours, it is likely that many individuals suffering from BN have never received a formal diagnosis.

This study is aimed at increasing our knowledge by looking at the lived experience of men who currently have or have recovered from binge eating and compensatory behaviours. The outcomes will be used to inform future research and therapeutic approaches to the treatment of BN and associated eating disorders.

MAKE A DONATION

You can support MGEDT by making a one-off or regular donation via JustGiving.

For more information please click on the logo below.

JustGiving

easyfundraising

The lived experience of men suffering from binge eating and compensatory behaviour – City University London is looking for male participants for a research study.

Have you at any time (now or in the past) eaten large amounts of food in one go and then gone to the gym to try to burn it off? Do/did you try to compensate for your eating in other ways, such as making yourself sick, using laxatives/other medications or dieting? If so, would you be willing to share your experience with us?

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This study is aimed at increasing our knowledge by looking at the lived experience of men who currently have or have recovered from binge eating and compensatory behaviours. The outcomes will be used to inform future research and therapeutic approaches to the treatment of BN and associated eating disorders.

To take part in this study you must be

- Male
- Aged between 18 and 65
- Have experience of binge eating and compensatory behaviour, commencing at least five years ago
- Not currently suffering from Anorexia Nervosa

If you agree to volunteer you will be asked to complete a questionnaire (usually filled in by the Researcher over the phone). If you match the requirements of the study you will be invited to take part in an interview exploring your experience of living with binge eating

Appendix C: Web summary advert

and compensatory behaviour. Participation will involve between 1 and 2 interviews of approximately 75 minutes each. These will be organised at a venue convenient to you. Confidentiality will be respected with all identifying information removed from the resulting research outputs and any associated publications.

In appreciation of your time, you will receive an honorarium of £40 and reimbursement of agreed travel expenses.

For further information about this study, or to take part, please contact the Researcher, Dr Matthew Stiff at [REDACTED]

Appendix D: Participant questionnaire

Part A. (to be completed over phone)

Surname:	_____	Forenames:	_____
Address 1.	_____		
Address 2.	_____		
Town:	_____		
County:	_____	Country:	_____
Postcode:	_____		_____

	_____	Mobile:	
Tel:	_____		_____

	_____	Preferred contact:	
Email:	_____		_____



**CITY UNIVERSITY
LONDON**

Part B. (to be sent to participant or completed by phone)

Place of birth:

Nationality:

Occupation:

Education:

Ethnicity (Please underline)

White (British)

Asian (Indian)

White (European)

Asian (Pakistani)

Asian (Bangladeshi)

Asian (Chinese)

Asian (Other)

Black

Mixed

Sexual Orientation: _____

Current height: _____ (Please specify units of measurement)

Current weight: _____ (Please specify units of measurement)

How stable has your weight been over the last six months?

- a. Very stable b. Moderately stable c. Moderately unstable d. Very unstable

Please answer the following questions as they apply EITHER now OR at some time in the past:

1. Have you ever been diagnosed with any of the following eating disorders (underline all that apply)
 - a. Anorexia
 - b. Bulimia
 - c. Binge eating
 - d. Other (please specify)

Appendix D: Participant questionnaire

2. If yes,
 - a. Was the majority of your childhood spent in the UK? **Yes/No**
 - b. Were you resident in the UK at the time of onset of your condition(s)? **Yes/No**
 - c. Have you continued to be resident in the UK for more than 75% of the time since you were diagnosed? **Yes/No**
 - d. Did you/are you receiving any counselling or psychotherapy? **Yes/No**
Type of therapy if known: _____
 - e. Is this therapy on-going? **Yes/No**

Please answer the following questions as they would apply to a period in your life when your binge eating and compensatory behaviour was most severe, either now or in the past:

1. When was your binge eating/compensatory behaviour most severe?
From: Month _____ Year _____ To: Month _____ Year _____ / Now
2. Do/did you at times eat noticeably larger quantities of food within a given period (e.g. 2 hours) than people would normally eat? **Yes/No**
3. Do/did you feel a lack of control at these times, either in terms of how much you are/were eating or feeling unable to stop? **Yes/No**
4. After eating large amounts of food do/did you compensate by
 - a. Making yourself sick? **Yes/No**
 - b. Taking laxatives, diuretics or other medications? **Yes/No**
 - c. Fasting? **Yes/No**
 - d. Exercising excessively? **Yes/No**
5. How many times per week do/did these episodes occur (Please state)?
Maximum: _____ Minimum: _____ Usual/Average: _____
6. What is the longest consecutive period of time during which these episodes have occurred on a weekly basis? ____ weeks ____ months ____ years
7. Overall, how long have/did these cycles of overeating and compensating last (please underline)?
 - a. 0-3 months
 - b. 4-6 months
 - c. 6-12 months

Appendix D: Participant questionnaire

d. More than 12 months (please state) _____

Please answer the following questions as they currently apply:

8. Have you been diagnosed with any of the following conditions:

a. Depression **Yes/No** Date: ___/___/___

b. Bipolar disorder **Yes/No** Date: ___/___/___

c. Obsessive-compulsive disorder **Yes/No** Date: -
___/___/___

d. Schizophrenia **Yes/No** Date: -
___/___/___

e. A personality disorder (Please specify) _____
_____ Date:
___/___/___

f. Any other condition affecting your mental health (Please specify)? _____

_____ Date: ___/___/___

9. Please describe your physical health?

10. Are you currently taking any medication?

11. Is there any other information that you would like to share about yourself that you think may be of importance to this study? _____

Appendix D: Participant questionnaire

Thank you for completing this form. Please return in the stamped-addressed envelope provided to the address below:

Matthew Stiff
Psychology Department
Social Sciences Building
City University
St Johns Street
London EC1R 0JD

Appendix E: Study information sheet



**CITY UNIVERSITY
LONDON**

Binge Eating and Compensatory Behaviours - Study information sheet

Title of study:

Binge eating and compensatory behaviours: A qualitative study of the lived experiences of adult men.

We would like to invite you to take part in a research study. Before you decide whether you would like to participate 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?

Bulimia Nervosa (BN) is a serious eating disorder affecting between 0.5% and 1.4% of adolescent males. Although more widespread among women, there is growing evidence to suggest that increasing numbers of men are susceptible to the condition. Because men often do not seek help with binge eating and compensatory behaviours (including vomiting, use of laxatives or other medications, excessive exercise, or dieting), it is likely that many individuals suffering from BN have never received a formal diagnosis. This study is being conducted as the research component of the Researcher's doctorate in counselling psychology undertaken at City University, London. It is aimed at increasing our knowledge by looking at the lived experience of men who currently have or have recovered from binge eating and compensatory behaviours. The outcomes of this study will be used to inform future research and to suggest ways in which the therapeutic approaches to the treatment of bulimia and associated eating disorders can be targeted more successfully to meet the needs of male patients.

Why have I been invited?

You have been invited to participate in this study because you responded to a request for participants and have indicated that you either now or in the past have been diagnosed with bulimia, or have experienced episodes of binge eating accompanied by compensatory behaviours.

To take part in this study you should be:

- Male
- Have experienced episodes of binge eating followed by compensatory activity such as vomiting, use of laxatives or other medications, excessive exercise, or dieting.
- Have experienced such episodes at least once a week for a period of three months or more.
- Have begun to experience such episodes at least five years prior to the commencement of this study.
- Have a good recollection of the circumstances surrounding your difficulties with binge eating and compensatory behaviours.
- Not currently suffering from Anorexia Nervosa.
- Aged between 20 and 65.
- Able to communicate comfortably in English.

If these criteria do not apply to you, or if you are uncertain please contact the researcher before completing the questionnaire or agreeing to participate in any interviews.

Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate in part or all of the project.

Should you agree to participate you are not required to answer any questions that you consider to be too personal or intrusive.

If you are a student and have been recruited via your university, it should be understood that your participation is not a requirement of your course and will not in any way affect your grades.

It is up to you to decide whether or not to participate. If you decide to do so, you will be asked to sign a consent form. You will remain free to withdraw at any time and without giving a reason.

What will happen if I take part?

If you agree to take part you will be asked to complete a short (3 page) questionnaire to confirm that you meet the criteria for the study and to gather additional background information covering contact details, demographic information, and information relating to your educational and medical background. Where possible this will be conducted by phone. You will also be asked a small number of questions relating to your experience of binge eating and compensatory behaviour.

You may then be asked to take part in an interview. This will consist of two parts: A short interview to clarify and confirm the content of the questionnaire
A longer, semi-structured interview (approximately one hour) to explore your experience of having bulimia nervosa.

The study is due to be conducted between November 2014 and September 2015. During this time it is possible that the Researcher may request a follow-up interview or clarification of any points raised in previous interviews.

A qualitative research method is being used, based on analysis of interview transcripts from between seven and eight participants. The research is taking place within the psychology department of City University. Interviews will be conducted either at City University or at a mutually-agreed venue.

Expenses and Payments (if applicable)

Agreed travel expenses and a payment of £40 in appreciation of your time will be paid to you should you take part in the interviews. These will be paid at the time of the interview.

What do I have to do?

If you would like to participate in this study, please complete the questionnaire enclosed with this information sheet. It is also possible to complete this with the Researcher over the phone should you prefer.

The Researcher will then contact you to arrange a suitable time and venue for you to be interviewed.

What are the possible disadvantages and risks of taking part?

It is possible that during the course of this study you will be reminded of circumstances or events that cause you distress. Should this occur please tell the Researcher about it as soon as possible. If this happens while you are being interviewed the interview will be suspended or terminated. The Researcher will make every effort to alleviate any distress felt and will direct you to other sources of support where appropriate.

What are the possible benefits of taking part?

The Researcher is training to be a counselling psychologist and it is possible that you will find the opportunity to discuss your experience of binge eating and compensatory behaviours to be therapeutic. You may also wish to share your experience with others and to draw attention to the ways in which the treatment and/or support of men with eating disorders can be improved.

What will happen when the research study stops?

Following completion of the study data will be retained until publication. All research material not included in the publication will then be destroyed.

Will my taking part in the study be kept confidential?

All digital data, including audio recordings, will be stored on an encrypted hard drive. Paper records will be kept in a secure filing cabinet. Anonymous participant numbers will be used to identify records, transcripts and audio recordings. Any identifying information will be removed from interview transcripts.

Only the Researcher and the Supervisor will have access to the original transcripts and audio recordings.

Contact information for participants will be retained for the sole use of allowing the Researcher or Supervisor to contact you in the future. This information will be deleted on request.

Information given during the course of interviews will be used for the purposes of the research and sections of transcript reproduced in the resulting thesis and any associated publications. While every effort will be made to remove any identifying material, it is possible that those people who know you very well will still be able to identify you. To minimize this risk you will be offered the opportunity to request the removal or further anonymizing of any such sections.

Your participation in this study will remain confidential. The only exceptions to this are in the event of you reporting acts of violence, abuse, recent self-inflicted harm, harm to others or criminal activity. Under such circumstances we may be legally obliged to share this information with others.

What will happen to the results of the research study?

The doctoral thesis arising from this research will be deposited in the library of City University, London, and made available to others on request. The data may also be used for further publications arising from the research, including articles in peer-reviewed journals, edited volumes and monographs. Anonymity will be maintained throughout publication. The doctoral thesis will be available for consultation at City University Library, as well as on inter-library loan. Electronic copies of journal articles will be emailed to you on request (copyright restrictions may require these to be in the form of “final drafts”).

What will happen if I don't want to carry on with the study?

You are free to withdraw from this study at any time and without providing any explanation. In such an event all material relating to your participation, including audio recordings, transcripts and interview notes, will be destroyed.

What if there is a problem?

In the first instance, please contact the Researcher or the Supervisor. Every effort will be made to address your concerns or resolve any difficulties.

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to 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 *Binge eating and compensatory behaviours: A qualitative study of the lived experience of adult men*.

You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London Northampton Square

Appendix E: Study information sheet

London
EC1V 0HB
Email: [REDACTED]

Who has reviewed the study?

This study has been approved by City University London Psychology Department Research Ethics Committee.

Further information and contact details

Dr Matthew Stiff
(Researcher),
Psychology Department
Social Sciences Building
City University
St Johns Street
London EC1R 0JD

Or

Dr Courtney Raspin (Supervisor)
Psychology Department
Social Sciences Building
City University
St Johns Street
London EC1R 0JD

(m) [REDACTED]
(e) [REDACTED]

(t) [REDACTED]
(e) [REDACTED]

Thank you for taking the time to read this information sheet.

Appendix F: Consent form

Consent form



Title of Study:

Binge-eating and compensatory behaviour: A qualitative study of the lived experiences of adult men in the United Kingdom

Please initial box

1.	<p>I agree to take part in the above City University 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 [researcher to add/delete as appropriate prior to use]:</p> <ul style="list-style-type: none"> • being interviewed by the researcher • allowing the interview to be audiotaped • completing questionnaires asking me about my binge-eating and compensatory behaviour. • making myself available for a further interview should that be required 	
2.	<p>This information will be held and processed for the following purpose(s):</p> <ul style="list-style-type: none"> • Analysis and comparison with data acquired from other participants during the course of this project • Inclusion of anonymised extracts in the project write-up and publications deriving from it <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>	
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 will be used only for the purpose(s) 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.</p>	
5.	<p>I agree to take part in the above study.</p>	

Matthew Stiff
(Researcher)

Signature

Date

Name of Participant

Signature

Date

When completed, 1 copy for participant; 1 copy for researcher file.

Appendix G: Debriefing sheet



CITY UNIVERSITY
LONDON

Binge eating and compensatory behaviour:

A qualitative study of the lived experiences of adult men in the United Kingdom

Debriefing note

Thank you for participating in this research study. The results will help us to understand more about male experience of binge eating and compensatory behaviour/bulimia nervosa and may help to inform new therapeutic responses that are targeted more specifically to the needs of men.

You are free to withdraw from this study at any stage without giving a reason for doing so. If you wish to withdraw you should contact the researcher (or their supervisor) and ask for your data to be withdrawn from the study within one month of the date shown on this form.

Due to the nature of the research, extracts from the interview will be used in the final report. To protect your anonymity all names, places and organisations will be changed. Only the interviewer and supervisor will have access to recordings. All recordings will be destroyed after publication of the research.

Upon completion of the interview you are free to ask any questions you may have about the interview or the research in general.

Further information and support relating to bulimia is available from NHS Choices (<http://www.nhs.uk/Conditions/Bulimia/Pages/introduction.aspx>).

There are also a number of organisations providing support to individuals suffering from binge eating and compensatory behaviour/bulimia nervosa.

If this interview raises distressing issues with you then you are welcome to discuss these with the Researcher. Alternatively, you may wish to talk in confidence with an appropriate support organisation. These include

ABC – Anorexia and Bulimia Care (<http://www.anorexiabulimiacare.org.uk>). ABC run a helpline: 03000 11 12 13.

B-EAT – Beating Eating Disorders (<http://www.b-eat.co.uk>). B-eat have a telephone support line: 0845 634 1414 as well as a support email address: help@b-eat.org.uk.

Appendix G: Debriefing sheet

MGEDT – Men Get Eating Disorders Too (<http://mengetedstoo.co.uk>). MGEDT holds online one-to-one live chat sessions on Wednesday evenings from 7.00-8.30pm. It also runs an online support group in the form of a discussion forum. Further information about these is available via the MGEDT website.

RCPsych - Royal College of Psychiatrists –
(<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/anorexiaandbulimia.aspx>)

The Samaritans (www.samaritans.org). 24-hour support is available by phone: 08457 909090 or by email: jo@samaritans.org.

Should you have any further questions, please contact:

Dr Matthew Stiff
(Researcher),
Psychology Department
Social Sciences Building
City University
St Johns Street
London EC1R 0JD

Or Dr Courtney Raspin (Supervisor)
Psychology Department
Social Sciences Building
City University
St Johns Street
London EC1R 0JD

(m) [REDACTED]
(e) [REDACTED]

(t) [REDACTED]
(e) [REDACTED]

Appendix H: Example of post-interview memo

Michael

24 January 2015 11:00

My first impressions of Michael were his friendliness and his height. He was much taller than I expected him to be. Although he seemed at ease, there was also a nervousness that confused me - I wondered whether this was always present or whether he was concerned about the interview process and what it might involve. In practice I felt that he relaxed and was open, but an element of the nervousness remained, suggesting that it may be constantly present. One aspect of the interview that felt awkward was Michael's assumption that he was much older than me - I had said at the beginning that I would be happy to answer his question on why I was interested in doing this research, but told him I would prefer to do so following the interview as I didn't want his knowledge of me to influence anything that he might say. This led to momentary feelings of awkwardness on my part as he explained to me what O'Levels were!

The overwhelming impression I had was one of a gentle giant, but there was also a sense of deep anger where his mother was concerned. Although no longer in contact with each other, her influence over him was palpable, affecting his choice of language.

I suspect that Michael saw through my vagueness following the interview when I said that I was motivated by the fact that "someone close to me" had an eating disorder - I wonder whether he thought it was my wife or my child (I suppose it could have been a brother or sister). I think that he found the experience to be positive but I realised afterwards how important it was to me that he shouldn't draw comparisons between myself and his mother. These thoughts were not present during the interview but I will need to be careful about them influencing future ones.

Overall I felt both pleased and alarmed by the richness of the material obtained. If there was any problem it was perhaps that I was too exploratory, resulting in an interview that was longer than it needed to be. The questions held up well though, and there does not seem to be any need to make alterations to the interview schedule.

Appendix I: Example of initial transcription

Transcript – Jack

1 **Interviewer:** So, you know, we're discussing...eating....

2 **Jack:** Mm.

Q1a – Do you have a name for it?

3 **Interviewer:**today, so can I just ask you a quick question.... Do you have a name for
4 your...eating?

5 **Jack:** No. I don't, actually.

6 **Interviewer:** Okay. So, I mean....are you kind of aware of the sort of names people use? Erm...D..do
7 you us any of those names, or...or...?

8 **Jack:** I di...What I find really hurtful... In my therapy they said, "Write a love letter...a love and a hate
9 letter..." Well, it was meant to be Anorexia your friend, Anorexia your enemy...erm....and I wrote it to
10 Anna. And I actually do.... I do find it easier to personify.

11 **Interviewer:** Yeah. So you have personified it as "Anna". Okay.

12 **Jack:** I do. And this is all kind of like subliminally and it's normally female. For me.

Appendix J: Example of initial coding

Transcript – Jo

Q0 – Tell me about yourself

1 **Interviewer:** Well, first of all, thanks very much for agreeing to talk to me. I mean, shall we just kick
 2 off.... Can you just tell me a little bit about yourself? Just...er... erm.... How old you are, what you're
 3 doing, where you were born.... That kind of thing.

4 **Jo:** Well, erm...erm...Ah [unintelligible] being twenty. Er, I was born in [Town A] and I live in [City A].
 5 Er... I'm a...a student there. Erm, so work...well, I volunteer in a charity, [Charity A]....

6 **Interviewer:** Mmhm.

7 **Jo:** ...er...where I hold the position of vice-chair.

8 **Interviewer:** Mmhm.

9 **Jo:** Er...so I'm currently...about to go into my third year of university in a [Degree Subject]
 10 undergraduate degree. And I'm living in [City A]...and studying at [University in City A]....

11 **Interviewer:** Okay, and you...er.... But you weren't born in [City A]?

12 **Jo:** No, I was born in [Town A]. It's....

13 **Interviewer:** Okay.

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Commented [MS1]: Town of birth; Town living in; Organisation volunteering with. Jo corrects himself from "work" to "volunteer". Is this conveying a sense of the difference in status? Does he think that unpaid work is somehow lesser?

Commented [MS2]: Work role. Use of word "hold" suggests ownership – indicative of pride in status?

Commented [MS3]: Current progress in university degree. Degree studied.

Commented [MS4]: Place living in.

Commented [MS5]: Place studying.

Commented [MS6]: Jo repeats information he gave only a few lines earlier. Sense of nervousness, possibly about the interview and its subject matter.

Commented [MS7]: Jo's responses are factual and delivered with minimal hesitation.

Commented [MS8]: City born in.

14 Jo: ...a wee town. Erm...on the other side from [City A].

15 Interviewer: Right.

16 Jo: Erm. That's where my family's from. That's where two of the younger members of my family still

17 live. Erm...the three...three older siblings and myself are...either in [City A] or moved on...erm...post-

18 graduation.

Q1 – How would you describe this pattern of eating and compensating?

19 Interviewer: Okay. Right. Erm... Well, just of sort of kick off, because obviously we...we're talking

20 today about, erm, men's live experience of binge eating and compensatory behaviour, so we... The

21 subject matter is eating disorders, and obviously I know that this is something that...that you know a lot

22 about because of the charity that you...that you work in. Erm.... But when you agreed to...to take part

23 in this...in this study, I...erm... You said that you had at times in the past eaten unusually-large

24 amounts of food in a short period of time, followed by a period of...compensatory behaviour.

25 Jo: Yes. Yes.

26 Interviewer: Yeah? Erm.... I wonder, could you...could you just describe that pattern of...of eating....

27 Jo: Erm.... There would be periods where I would lose control. Erm....and, just sort of shut down and

28 eat everything in sight. If I was at home, and it would mostly be, like, tinned foods.

Commented [MS9]: Description of city born in.

Commented [MS10]: Provides context for Place born in. Suggests parents also came from this town.

Commented [MS11]: Where his younger siblings live.

Commented [MS12]: Where his younger siblings live. Older siblings no longer live there.

Commented [MS13]: Jo uses words like "younger members" and "siblings" rather than "brothers" or "sisters". Does this indicate detachment or separation from his family? A sense of otherness?

Commented [MS14]: Los off control

Commented [MS15]: Loss of control is time bounded. Creates sense of it being a phase in a process.

Commented [MS16]: Stops functioning. Shut down conveys impression of machine-like behaviour. Is Jo conveying a sense of an ED episode being automatic and beyond individual control?

Commented [MS17]: The consequence of loss of control.

Commented [MS18]: Where he would usually binge eat. Patterns of behaviour in EDs.

Commented [MS19]: Preferred binge foods

29	Interviewer: Mm.	
30	Jo: Erm... You know, I'd have like five cans of kidney beans, five cans of chickpeas, erm, tinned	
31	custard and rise pudding...	Commented [MS20]: Preferred binge foods.
32	Interviewer: Mm.	
33	Jo: It's because they were... directly available. They didn't require any...any...any...necessarily any	Commented [MS21]: Reason for choice of foods – Availability.
34	cooking.	Commented [MS22]: Foods don't require cooking. <i>Jo stumbles here. Is this indicative of feelings associated with eating food cold that is normally eaten warm? Embarrassment? Shame?</i>
35	Interviewer: Mm.	Commented [MS23]: Process of binge eating.
36	Jo: Erm... I'd often eat, like, straight from the can, so I'd end up cutting my mouth open.	Commented [MS24]: Immediate consequences of binge eating. Implies tipping food from can directly into mouth with no use of cutlery. Suggests ED episodes cause people to behave outside of normal conventions.
37	Interviewer: Right,	Commented [MS25]: Loss of control. Automatic behaviour. Lack of awareness.
38	Jo: Erm... But it was never something that I was...really aware of or in control of.... Erm, but then	Commented [MS26]: Binge eating as a time-limited phase.
39	after...after that sort of period passed there would be....waves of guilt. I'd often go out and replace the	Commented [MS27]: Emotional response - Guilt Suggests that after the loss of control and awareness, self-reflection kicks in resulting in an emotional response.
40	food, any food that I'd taken from the sort of family kitchen....	Commented [MS28]: Restorative behaviour – Replacement of food taken. <i>Jo describes the food as "taken from the...family kitchen". Suggestive of theft of food. Conceptual criminalising of ED episode?</i>
41	Interviewer: Mm.	Commented [MS29]: Compensatory behaviours. <i>Jo places this directly after describing waves of guilt and replacing the food "taken". What are the reasons for purging? Is it just to get rid of the calories or is there a punitive element related to the taking of food?</i>
42	Jo:and...then I would engage in compensatory behaviours. Erm... Vomiting was never an option. It	
43	was attempted on several occasions, but never worked.	

Appendix K: Example of emergent themes in NVivo

Counselling Psychology Thesis - Production.mpx - NVivo Pro

FILE HOME CREATE DATA ANALYZE QUERY EXPLORE LAYOUT VIEW

Workspace Refresh Open Properties Edit Paste Merge Clipboard

Format B I U | A | Paragraph Styles

Reset Settings Find Now Clear

PDF Selection Text Region Editing

Select Find Replace Delete

ABC Spelling Proofing

Look for Themes

Advanced Find

Nodes

- Master Themes
- Themes
- Cases
- Relationships
- Node Matrices

Sources

Nodes

- Classifications
- Collections
- Queries
- Reports
- Maps
- Folders

MS - 12/0 Items

Name	References	Created On	Created By	Modified On	Modified By
Being Caught Out	1	11/04/2016 13:08	MS	20/04/2016 17:08	MS
Being Cool	1	13/04/2016 15:12	MS	20/04/2016 17:08	MS
Being dropped	2	10/04/2016 16:37	MS	20/04/2016 17:08	MS
Being Good	2	27/03/2016 14:02	MS	20/04/2016 17:08	MS
Being in the Wrong	1	10/04/2016 01:34	MS	20/04/2016 17:08	MS
Being Judged By Others	1	11/04/2016 13:04	MS	20/04/2016 17:08	MS
Being Laughed At	1	25/03/2016 23:40	MS	20/04/2016 17:08	MS
Being Left Out	1	13/04/2016 15:15	MS	20/04/2016 17:08	MS
Being Lithe	1	13/04/2016 16:19	MS	20/04/2016 17:08	MS
Being Naughty	2	27/03/2016 14:02	MS	20/04/2016 17:08	MS
Being Remembered	1	14/04/2016 00:30	MS	20/04/2016 17:08	MS
Being Remembered	1	12/04/2016 23:03	MS	20/04/2016 17:08	MS
Being Skinny	3	12/04/2016 23:03	MS	20/04/2016 17:08	MS
Being Stuck	1	23/02/2016 14:04	MS	20/04/2016 17:08	MS
Being Told Off	1	09/04/2016 23:10	MS	20/04/2016 17:08	MS
Being Uncool	1	13/04/2016 16:18	MS	20/04/2016 17:08	MS
Being Useful	1	16/02/2016 22:02	MS	18/05/2016 20:49	MS
Beliefs - Catching Calories	1	07/02/2016 23:25	MS	18/05/2016 20:49	MS
Beliefs - Flushing Out Calories	1	21/02/2016 12:16	MS	18/05/2016 21:06	MS
Beliefs - Healthy Eating	1	21/02/2016 12:17	MS	18/05/2016 21:06	MS
Belonging	2	24/02/2016 16:39	MS	20/04/2016 17:08	MS
Betrayal	2	11/02/2016 00:43	MS	18/05/2016 20:49	MS
Birth of Sibling - Displacement	1	27/03/2016 16:30	MS	20/04/2016 17:08	MS
Birthplace	1	27/03/2016 13:37	MS	20/04/2016 17:08	MS
Blame	2	10/02/2016 00:33	MS	18/05/2016 20:49	MS
BMI - Usefulness	2	16/02/2016 19:36	MS	18/05/2016 20:49	MS

Appendix L: Example of theme clusters in NVivo

The screenshot displays the NVivo software interface, specifically the 'Themes' window. The window shows a list of themes created from sources, with columns for Name, Sources, References, Created On, Modified On, and Modified By. The themes are organized into clusters, such as 'Parents' and 'Mother'. The 'Parents' cluster includes themes like 'Absent Parent', 'Father', 'Father - Comparisons with', 'Father - Critical', 'Father - Death of', 'Father - Illness', 'Father - Mentally Abusive', and 'Father - Physically Abusive'. The 'Mother' cluster includes 'Mother - Older Mother', 'Mother - Pleasing', and 'Parental Absence'. Other clusters include 'Parents - Academically Nurturing', 'Parents - Age', 'Parents - Blaming', 'Parents - Credit-taking', 'Parents - Communication Problems', 'Parents - Controlling', 'Parents - Criticizing', 'Parents - Difficulties in Childhood', 'Parents - Estrangement', and 'Parents - Favouritism'. The 'Modified By' column for all entries is 'MS'. The 'Created On' and 'Modified On' columns show dates ranging from 08/02/2016 to 09/04/2016.

Name	Sources	References	Created On	Modified On	Modified By
Parents		7	08/02/2016 16:08	18/05/2016 20:50	MS
Absent Parent		1	17/02/2016 23:38	18/05/2016 21:06	MS
Father		6	10/02/2016 23:32	18/05/2016 21:06	MS
Father - Comparisons with		1	11/02/2016 00:19	18/05/2016 20:49	MS
Father - Critical		1	24/02/2016 15:54	20/04/2016 17:14	MS
Father - Death of		2	23/03/2016 23:04	20/04/2016 17:14	MS
Father - Illness		1	23/03/2016 23:06	20/04/2016 17:14	MS
Father - Mentally Abusive		1	10/02/2016 23:31	18/05/2016 20:49	MS
Father - Physically Abusive		1	10/02/2016 23:30	18/05/2016 20:49	MS
Mother		7	08/02/2016 16:07	18/05/2016 21:06	MS
Mother - Older Mother		1	26/03/2016 00:22	20/04/2016 17:08	MS
Mother - Pleasing		1	27/03/2016 16:21	20/04/2016 17:08	MS
Parental Absence		1	20/02/2016 14:27	18/05/2016 21:06	MS
Parents - Academically Nurturing		1	23/02/2016 11:56	20/04/2016 17:13	MS
Parents - Age		2	23/02/2016 11:07	20/04/2016 17:13	MS
Parents - Blaming		1	08/04/2016 15:20	20/04/2016 17:13	MS
Parents - Credit-taking		1	27/03/2016 18:39	20/04/2016 17:13	MS
Parents - Communication Problems		3	23/02/2016 11:06	20/04/2016 17:13	MS
Parents - Controlling		1	12/04/2016 23:34	20/04/2016 17:13	MS
Parents - Criticizing		2	08/04/2016 12:38	20/04/2016 17:13	MS
Parents - Difficulties in Childhood		1	23/03/2016 21:53	20/04/2016 17:13	MS
Parents - Estrangement		1	09/04/2016 22:41	20/04/2016 17:13	MS
Parents - Favouritism		1	09/04/2016 22:40	20/04/2016 17:13	MS

Appendix M: Theme master table within NVivo

The screenshot displays the NVivo interface with the Master Themes table and a text excerpt. The table lists various themes with their respective source counts and reference counts. The text excerpt shows a conversation between an interviewer and a participant named Clive, discussing experiences with men and control.

Name	Sources	Referen
Experiences of help seeking	0	0
Men as other	7	30
Therapy fit for men	5	12
Gendered bodies and identity	0	0
How men experience their bodies and	7	29
What does it mean to be male	6	23
Painful parenting experiences and their co	0	0
Deprivation and neglect by parents	5	14
Family issues with food and body/imag	7	26
Parental fear and control	4	24
The need for, and loss of, personal power a	0	0
Being invisible	6	11
Control of the ED	7	20
Exerting control	5	20
Loss of emotional control	7	29

Text Excerpt:

Interviewer: Mm.

Clive: ...in both their families, and they just... They didn't know what to make of me... And I struggled dreadfully with puberty.

Reference 1 - 0.14% Coverage

Reference 2 - 1.83% Coverage

And ...but there was always conflicting messages about it, so... I was given the kind of the birds and the bees style talk and the ...you know...I knew what to expect...Er... technically. From a...you know. On paper, in a text-book kind of way. I just wasn't prepared for it starting so early. And I was really embarrassed about that, so you know things like facial hair and...pubic hair and all that kind of stuff. I was twelve when that started.

Interviewer: Mm.

Clive: ...And...and I remember I was deeply embarrassed and I got...I was...my groin was really itchy and I got my mum to...I didn't want to, but it was itching such a long time...I got

Appendix N: Ethics release form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the School does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ↑ M.Phil ↑ M.Sc ↑ D.Psych n/a ↑

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Binge-eating and compensatory behaviour: A qualitative study of the lived experiences of adult men in the United Kingdom

2. Name of student researcher (please include contact address and telephone number)

Dr Matthew Stiff
19 Riverside Road
Oxford
OX2 0HT

(e) [redacted]
(m) [redacted]

3. Name of research supervisor

Dr Courtney Raspin
Psychology Department
City University

(e) [redacted]
(t) [redacted]

Appendix N: Ethics release form

4. Is a research proposal appended to this ethics release form? **Yes**

5. Does the research involve the use of human subjects/participants? **Yes**

If yes,

a. Approximately how many are planned to be involved? **10-12**

b. How will you recruit them?

Participants will be recruited via online support groups and discussion fora; in particular:

Men Get Eating Disorders Too (MGEDT) - <http://mengetedstoo.co.uk/>

Beating Eating Disorders (B-Eat) - <http://www.b-eat.co.uk/>

Both MGEDT and B-Eat support research into eating disorders and facilitate the recruitment of participants. In particular, B-EAT maintains a database of potential participants and makes provision for researchers to advertise the research on its website (B-Eat, 2010). It is hoped that the sample will contain participants with a range of compensatory behaviours including purging, exercise and laxative use.

Consideration will be given to recruiting via the NHS, subject to ethical approval. Additional and/or more targeted recruitment may be required, possibly using other fora including those dealing with men's health and exercise. Similarly, permission may be sought to advertise for participants in sports clubs, universities and gymnasias should online recruitment fail to generate sufficient participants.

All participants will be reimbursed for travel expenses and an honorarium offered to compensate for their time in completing the questionnaire and participating in interviews.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

Participants will be screened to ensure that they have met the DSM-5 diagnostic criteria for bulimia nervosa. They should also meet the following additional criteria.

- Male
- Have met the diagnostic criteria for bulimia nervosa at least five years and no more than thirty years prior to the commencement of the study. Aged between 20 and 65.
- Able to communicate comfortably in English.
- Currently resident within the United Kingdom as well as for the majority of their upbringing and during the onset of their bulimia nervosa. This is to facilitate data collection and to provide a more uniquely UK perspective.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? **No**

d1. If yes, will signed parental/carer consent be obtained? **N/A**

d2. If yes, has a CRB check been obtained? **N/A**

Appendix N: Ethics release form

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? (If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).

Participants will be asked to complete an initial questionnaire to ensure that they meet the recruitment criteria and to capture additional information relating to demographics, medical history and comorbidities.

Participants meeting the criteria will participate in an interview consisting of two parts. The first will be used to verify and augment information gathered using the questionnaire. Following a break a second semi-structured interview lasting approximately one hour will explore their experience of bulimia nervosa.

Following analysis of the data participants may be asked to take part in additional follow-up interviews and/or to comment on/clarify transcripts of their interviews.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes

If yes,

a. Please detail the possible harm?

A particular risk exists if a participant is actively anorexic, and for this reason such participants will not be included in this study. It is also possible that other comorbidities may be present that would put participants at risk were they to take part in the semi-structured interviews.

It is always possible that individuals may experience psychological and/or emotional distress when recalling experience of a condition such as bulimia nervosa. It is expected that this risk will be minimal as participants will have a large degree of control over what they talk about and, having been diagnosed with bulimia at least five years prior to the onset of the study, are more likely to have come to terms with the condition.

b. How can this be justified?

The overall risk and impact is perceived to be low. The study is justified by the comparative lack of research on male experience of bulimia. Particularly in the UK population. By adhering to Rogerian core conditions it is also possible that the interviews themselves may have a therapeutic effect.

c. What precautions are you taking to address the risks posed?

Participants will be screened to ensure that their BMI falls within the normal range. In addition, any participant reporting as being currently anorexic during the initial recruitment phase will also be excluded, regardless of their BMI. Where other comorbidities are identified during the recruitment phase, a cautious approach will be adopted and advice taken to minimise risk before allowing individuals to participate in the semi-structured interviews.

Appendix N: Ethics release form

Interviews will be conducted with emphasis on Carl Rogers' core conditions, in particular empathy, congruence and unconditional positive regard. The well-being of participants will be monitored throughout. If at any time a participant becomes distressed the interview will be paused or terminated. Every effort will then be made to alleviate this distress using grounding techniques and allowing the participant to explore their feelings.

Participants will be made aware of appropriate support groups, including BEAT, MGEDT and the Samaritans. They will also be able to contact the researcher should they experience distress subsequent to the interviews taking place.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

- Contact details
- Questionnaire responses
- Audio recordings
- Interview transcripts
- Written notes from meetings/interviews
- Transcript database

12. What provision will there be for the safe-keeping of these records?

Recordings and all other digital information will be held on a computer with an encrypted hard drive. Written notes will be stored in a locked filing cabinet and will not include any identifying information other than participant numbers.

Appendix N: Ethics release form

13. What will happen to the records at the end of the project?

All material not in the public domain will be destroyed following publication of the research. This will include all audio recordings, records and non-anonymised interview transcripts.

14. How will you protect the anonymity of the subjects/participants?

All participants will be allocated an identifying number which will be matched with their contact information record. This number will be used to identify all digital and analogue records. Names of participants will be held separately from the data and will not appear in any research outputs.

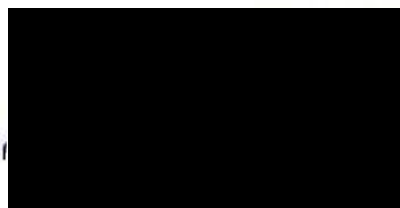
15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

All participants will be supplied with a debrief information sheet and given the opportunity to verify and/or clarify their information. They will also be given an opportunity to talk to the researcher and discuss the outcomes of the research. They will also be encouraged to discuss any distressing thoughts or feelings with the researcher. Should they need any additional psychological support they will be informed of support groups and relevant sources of information, including NHS Choices, ABC, B-EAT, MGEDT and the Samaritans.

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student research



13/11/2014
----- Date -----

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal	X
Recruitment Material	X
Information Sheet	X
Consent Form	X
De-brief Information	X

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? **Yes**
If yes,

a. Please detail possible harm?

It is possible that as I am close to someone who has experience of bulimia nervosa I may find aspects of this work distressing. I consider this risk to be low and of low impact should it occur.

b. How can this be justified?

I consider the risk to be justified by the increased understanding of the impact of binge-eating and compensatory behaviours on men that the project will provide, both to myself and to the broader community.

c. What precautions are to be taken to address the risks posed?

I will explore my feelings using a reflective journal and will undertake personal therapy throughout the duration of the project.

Section C: To be completed by the research supervisor

(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

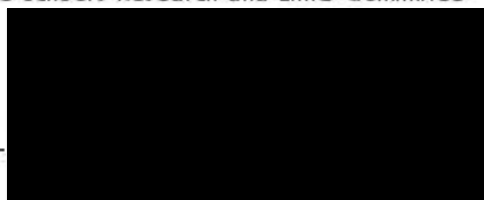
Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature -



Date

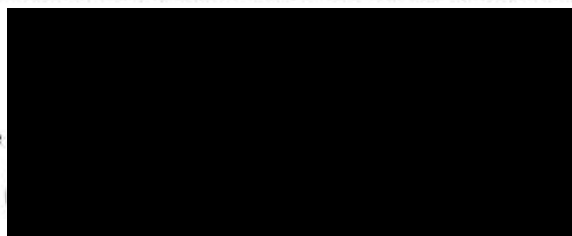
13/11/14

Section D: To be completed by the 2nd Departmental staff member

(Please read this ethics release form fully and pay particular attention to any answers on the form where **underlined bold** items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature



Date

13/11/2014

Appendix O: *Counselling Psychology Review publication guidelines*

The following information is provided for contributors to *Counselling Psychology Review*.

Other guidance is provided in the BPS Style Guide (BPS, 2017) .

Information for contributors

1.Length:

Papers should normally be no more than 6,000 words (including abstract, reference list, tables and figures).

2. Manuscript requirements:

- The separate **cover page** should be completed. Contact details will be published if the paper is accepted.
- Apart from the cover page, the document should be free of information identifying the author(s).
- Authors should follow the Society's guidelines for the use of non-sexist language and all references must be presented in the Society's style, which is similar to APA style. For an electronic copy of the Society's Style Guide, go to the Publications page of www.bps.org.uk and then click on Policy and guidelines/General guidelines and policy documents and choose Society Editorial Style Guide from the list of documents).
- A structured abstract of up to 250 words should be included with the headings: Background/Aims/Objectives, Methodology/Methods, Results/Findings, Discussion/Conclusions. Review articles should use these headings: Purpose, Methods, Results/Findings, Discussion/Conclusions.
- Approximately five keywords should be provided for each paper.
- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc., for which they do not own copyright.
- Graphs, diagrams, etc., must have titles -these should not be part of the image.
- Submissions should be sent as email attachments. Word document attachments should be saved under an abbreviated title of your submission. Include no author names in the title. Please add 'CPR Submission' in the email subject bar. Please expect an email acknowledgment of your submission.
- Please make all changes after review using Track Changes and return them to the Editor.

