Nourishing Hunger and Embodied Resistance: Men’s Narratives of Eating Disorders

by

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Abstract

This qualitative research study curates the voices of five male-identified subjects who experience or who have lived with anorexia nervosa. The purpose of this endeavour is to engage with a reading of anorexic embodiment that sidesteps the lenses of psychopathology and somatic abnormality in order to highlight the interpretations articulated by the men via their own vocabulary. Although this research does not discount anorexia's dangerous implications, it still asks us to consider what the willful practice of hunger does to our understandings of performed masculinity and "healthy" bodies. What emerges is a notion of anorexia as a form of alterity and resistance alongside normative, etiological interpretations of it as a disease/disorder. This complex rendering of subjectivation - both by and about the participants - may further inform researchers and practitioners in negotiating anorexia as a phenomenon of knotted intersections and meaningful manifestations as opposed to a strict medical problem that requires intervention-based solutions.
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“Always more, always hungrily scratching for more. But there were times, quiet moments, when… we wanted less: less weight, less work, less noise, less father, less muscles and skin and hair. We wanted nothing, just this, just this.”

- Justin Torres, *We the Animals*
**Introduction**

This research project aims to bring forth the narratives of male-identified individuals who have lived or continue to live the experience of what is typically referred to in Western cultures as “anorexia nervosa”\(^1\). Although the literature on anorexia nervosa and other eating disorders continues to develop on the category of “men”, much of it tends to reiterate outdated tropes and notions that require re-interrogation. As a “recovering” anorexic male, I am attentive to how anorexia continues to be imagined in particularly gendered and strictly performative ways, namely through arguments regarding modes of treatment and theories of causality typically geared toward women and girls.

My project begins with a close reading of the biomedical texts that locate and describe anorexia nervosa (Chapters 1 - 2). By casting a critical gaze upon the textual presence of anorexia, cultural and social notions about the healthy (male and female) body begin to appear. In looking to how anorexia manifests upon the human form (or how it is made manifest), we can consider how it is diagnosed. And finally, by examining the practices of the clinic, we see how anorexia is treated; in effect, how the bodies of anorectics are managed and studied. Then, I move onto presenting my own research and findings (Chapters 3 – 6), contrasting the prior discourse with the voices of male-identified subjects living with anorexia.

From the age of ten, my own body has been the site of repair, breakdown, and judgment - though not always performed by myself alone. As I argue later, the aspects of embodiment that require a witness’s testimony and/or appellation also inform the

\(^1\) In this study, I use this term as both medical diagnosis (see Appendix A) and as a culturally-organized understanding of corporeal phenomena in need of theorizing.
anorectic’s practice. Although practiced hunger (that is, one way to understand anorexia nervosa) is the condition that has manifested most acutely for me, bulimia nervosa, orthorexia nervosa, EDNOS (Eating Disorder Not Otherwise Specified), exercise purging, and cleansing are also significant practices in my life and continue to be. Looking back, the resources that I accumulated during medical treatment did not seem to fully encompass the tenor of my experiences, particularly because the diagnostic criteria for anorexia were - and continue to be, I claim - weight- and BMI-based.

Many such texts and documents even assume that the body in question is that of a biological female; intake forms asked, for example, whether my symptoms included amenorrhea. My weight loss and refusal to eat was understood to be a result of a severe psychological or medical illness, and I was often encouraged to seek treatment and help by observers who could not make sense of the coalition of my gender and bodily articulation. Friends and family members would plead, threaten, and coerce in order to facilitate weekly visits to the family doctor. Indeed, this motif was constant throughout my treatment: the notion that the anorectic’s form was a site of nervous, aberrant conditions, at risk of self-harm and in need of swift intervention. These scripts seemed to only conceptualize eating disorders as a psychosomatic effect borne out of trauma, control issues, and/or suicidal leanings.

Like any other biological or bodily phenomena, the biomedical “reading” of anorexia nervosa makes possible certain types of discourse and relations at the same time that it excludes others. An anorectic is assessed against a predictable set of diagnostic criteria that are taken as unquestioned, and objectively located on or within the body. I discuss this in greater detail in Chapter 1, in which the DSM-5’s entry on anorexia
nervosa by the American Psychiatric Association lists diagnostic criteria, risk factors, and prevalence. Such an approach, in the words of Lock and Farquhar “reinforce[s] the idea that diseases are entities in themselves, affecting all bodies similarly, knowable in isolation, and in theory without moral, social or political significance” (436). This approach surely obscures the roles that culture and social relations play in managing what kinds of bodies are deemed healthy or otherwise.

It is my hope to reframe anorexia nervosa beyond a manifestation of psychopathologies, or that of a social pressure to conform to particular aesthetic ideals enforced by mass media and cultural norms. While these may well be compelling and even accurate lines of inquiry, what other ways can we discuss anorexia through an interpretive sociological lens? By curating and valuing the voices of anorectic men, what can we tease out that a strictly quantitative or biomedical approach may fall short of addressing? How can the lens of gender critique orient us to the gendering of anorexia, and how might disability theory account for the locating of anorexia in pounds or kilograms (i.e. in that weight itself is a culturally organized phenomenon)? By parsing out the absolutes that come to mind when visualizing what anorexia is, or what it is culturally imagined to be, I hint at a richer terrain through attending to and interacting with the voices of male-identified people who can speak to a life with anorexia.

This is unique in that the words of doctors, pamphlets, and medical textbooks are usually the most prevalent voice in anorexia discourse and thus influential; moreover, “patients” absorb this terminology and its connotations, in turn diagnosing their own bodies. Even if these individuals living with anorexia are to reject these resources, this is an important reactionary response. What then does anorexia become when removed from
these scripts? What does it become when it is written by those whose very bodies are being scrutinized? Qualitative approaches - such as interviews, journals, and art – often seem sidelined in the interest of research that lists statistical results, briefly comments on recurring motifs, and formulates conclusions based on those considerations. Five years of working as an ESL educator has also compelled me reflect upon the limits of language, and how it can both enable and foreclose an articulation about complex phenomena.

So then, burdened with loaded terms in gazing upon an anorexic body, what is the prior literature assuming about the subjects involved in the research? In what ways is a “high-risk” study on eating disorders perhaps already suggesting about how the participants govern their own bodies? My intention here is to grasp what is occluded in other work about anorexia by asking my participants to consider what their experiences are, but without complete domination by or reverence for the terminology of medical or psychiatric discourse, nor its more popular expressions. I will, in the subsequent chapters, analyze examples of the quantitative biomedical approach before moving onto the narrations made by the participants in this study.

This research project begins with a consideration of how anorexia is coded as a psycho-pathological problem in need of a solution, particularly through the deployment of scientific and rationalizing language to narrate the condition (Chapter 1). I will also provide a brief literature review regarding the presence of male-identified patients in eating disorder studies (Chapter 2). I make the case that while males have been represented in research about anorexia nervosa and other EDs, their full, active participation is wanting. In effect, I claim that fieldwork in the vein of narrative inquiry is vital in order to inform the clinic of the lived experience of anorexia nervosa, not solely
observational analysis by researchers and medical practitioners.

Although quantitative studies on males with eating disorders are absolutely central in terms of informing medical support, this research project aims to re-centre the focus via interviews. My desire to help (co-)narrate this project is to bring forward the voices of male-identified individuals who have experienced the following – stigma and shame, misunderstanding on the part of doctors, and a feeling of being alienated by services offered by the health care system (namely in the province of Ontario). Not always, but often, male anorectics must navigate and circumvent a culture that is not quite sure how to make sense of their bodies. And if their bodies are deemed acceptable for treatment, they are assessed based on possible triggers, behavioral classifications, or they are evaluated through numbers based on pounds gained or eliminated. While these markers could very well be instrumental for particular types of research, what I am suggesting is that in sharing others’ stories, the full picture is much more knotted than such clinical and linear data would suggest. This is why my research includes these five participants who, in open-ended interviews, describe how they began to perform anorexia, narrate their experiences of it, and lend their perspectives on the question of recovery (Chapter 3).

So then, if anorexia nervosa can be conceptualized as more than a medical problem in need of intervention, what else could it possibly be? Overall, this research project will address how these male-identified individuals give voice to their bodies in ways that complicate the long-held understanding of a condition as one that affects primarily women. How can we account for the male-identified populations that have been rendered largely invisible - or an aberration - in eating disorder literature? Patrick Anderson, a scholar whose work on males and EDs has been deeply influential on this research
project, regards male anorexia as a “problem” for biomedical science. More specifically, anorexia in males is

a category of cultural practice that works against the conventional masculinity anticipated for men and enforced at the site of the male body, representing both the gendered nature of modern medical practice and insistent, if dangerous, mode of resistance to cultural expectations for how differently gendered bodies are compelled to consume. (Anderson, 155, 2008)

While Anderson acknowledges the dangerous, real-life implications of self-starvation, he also suggests that beyond the medical gaze, there is a narrative about gender performance and embodied resistance in terms of how bodies are coded. And as Hepworth reminds us in The Social Construction of Anorexia Nervosa, femininity and/or being female is a “predisposing factor for diagnosis... [and] a key construct in articulating the development of psycho-pathology that maintains that anorexic state” (81). I am interested then in how the practice of male anorexia presents an affront: to how men are expected to consume, and to how this (image and performance of) starvation violently ruptures that gendered normalcy. And this is why I will conclude with recommendations for health care practitioners and educators in their treatment and consideration of ED male individuals.
Chapter 1: The Clinical Conceptualization of Anorexia Nervosa and Men (DSM-5)

In Reading Disability Differently: The Textured Life of Embodiment, Tanya Titchkosky calls the reader’s attention to the legitimacy of texts, particularly those locating disability and otherness, and how this discourse comes to define phenomena related to embodiment. That is, difference is enacted in language because it is interpreted as such, and results in hierarchies of corporeality. As such, despite such rhetoric scripting normalcy (and by extension, that which is not normal), people regard it as objective because normalcy is ostensibly rooted in empirical, scientific observation and its own version of what objectivity “looks like” (91). Furthermore, biomedical and psychiatric knowledge has come to dominantly govern how we relate to our bodies, and is used to create benchmarks of health. In his book The Body and Social Theory, Chris Shilling discusses how modern science has increasingly intervened at the site of the body, while at the same time “destabilizing our knowledge of what bodies are, and runs ahead of our ability to make moral judgments about how far science should be allowed to reconstruct the body” (3). This is of concern to the study of anorexia nervosa because the medical and psychiatric clinics have hitherto been regarded as the prevailing word on not only treatment of the condition, but also on its roots and causes.

It is with these considerations that I move to a crucial document in understanding how the clinic produces anorexia nervosa as a disorder that can be measured and constituted as abnormal. The American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders (hereafter referred to as DSM-5) is a significant resource that health care practitioners use in diagnosing and treating patients with disabilities and disorders. While the DSM-5 is not universally embraced, it is still useful
for my discussion for three reasons: first, it informs how medical practitioners identify
symptoms in anorectics; second, it is written from the perspective of an external “expert”
arbiter; third, it is a widely used and accepted text through which the ordinary
regulation of life into a medical condition is accomplished and thus a prime scene to
uncover the limits and possibilities of the biomedical approach. The actor who makes use
of the document – or the audience addressed by the document – is in all likelihood the
clinician, and ultimately, the beholder of the anorexic’s body (i.e., the object of the
document). The entry manages to “report” anorexia without really engaging with the
phenomenology of the anorectic’s experience(s).

Below is a brief excerpt from the *DSM-5* entry on anorexia nervosa; the full section
can be found in Appendix A of this thesis. The visual layout of the text here is telling –
the bold typeface label of the condition suggests something that can be measured and
observed. The entry conspicuously lacks a subject (i.e., a human) but nonetheless narrates
a condition of disembodied actions and characteristics:

Figure 1. Excerpt on Anorexia Nervosa from the *DSM-5*

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**Anorexia Nervosa**

**Diagnostic Criteria**

A. Restriction of energy intake relative to requirements, leading to a significantly low body
weight in the context of age, sex, developmental trajectory, and physical health. Sign-
ificantly low weight is defined as a weight that is less than minimally normal or, for
children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes
with weight gain, even though at a significantly low weight.
While it is understandable that an encyclopedic entry – directed to an audience of medical scholars and clinicians – must narrow its focus for easeful diagnosis, this brief DSM-5 entry (spanning a mere eight pages) exemplifies the disorder of anorexia nervosa through rational, scientific analysis. In this document, anorexia can be narrated precisely because it is coded as a departure from healthy bodies “in the context of age, sex, developmental trajectory, and physical health” (American Psychiatric Association, 338), all of which are presented as a priori standards of normalcy. Indeed, one of the diagnostic criteria (Criterion A) for anorexia nervosa is “significantly low weight... [and] defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected” (338; my emphasis). And interestingly, an “individual” or subject is not brought into focus until after the symptoms are listed, when subtypes of anorexia nervosa are coded (339). This further objectifies (and makes abstract) the condition of anorexia nervosa away from the actual bodies of people.

Presumably, this aforementioned usage of “normal” in Criterion A is defined by Body Mass Index (BMI) calculations, which are determined by the Centers for Disease Control and Prevention (CDC) and by the World Health Organization (WHO), both of which are also cited in the entry (340). By this benchmark of numerical fixity, bodies are

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2 See Appendix A.2 for entry on anorexia nervosa from ICD-10 (International Classification of Diseases and Related Health Problems) published by the World Health Organization. The very brief paragraph addresses gender to the extent that it occurs “most commonly” in adolescent girls and young women, but also notes that “adolescent boys and young men may also be affected” (World Health Organization, 2010). The text differs slightly from the DSM-5 in that it explicitly narrates a “patient” that induces and sustains deliberate weight loss (ibid). Still, anorexia is narrated as a “disorder” and a “psychopathology” (ibid), objectified as a condition of detectable symptoms and manifestations.
placed into categories of mild, moderate, severe, and extreme thinness (339). Of particular interest to me is this emphasis on scale figures; if an individual does not meet the criterion of low body weight, he or she is seen to be in “partial remission” (339), even if he or she exhibits characteristics described in Diagnostic Criteria B and/or C. Since most eating disorders actually fit into the EDNOS category, this diagnostic criteria is indeed problematic (Darcy, Lin, 65).

This is an implicitly epidemiological claim in the DSM-5: anorexia nervosa is primarily diagnosed and treated upon the corporeal body. Anderson confirms that it is still a “shocking” standard for treatment in many clinics that a “minimum body weight must be achieved before a given patient may be admitted” (155, 2008). This emphasis on bodily appearances (i.e. weight) as symptoms over practices that exhibit control or intention does not take into account how some may still identify with the disorder (in terms of reclaiming it, as a politics for subcultural positioning such as “pro-anorexia”, or otherwise) despite not exemplifying a low body weight by BMI standards. More concerning is how the subjectivity of the patient is arguably of no practical use or even validity to the writers of the DSM-5. In fact, there is an ongoing dismissal of the anorectic’s point of view as irrational and disconnected from objective truth:

> It is rare for an individual with anorexia nervosa to complain of weight loss per se. In fact, individuals with anorexia nervosa frequently either lack insight into or deny the problem. It is therefore important to obtain information from family members or other sources to evaluate the history of weight loss and other features of the illness. (American Psychiatric Association, 340; my emphasis)

Revealingly here, the DSM-5 acknowledges the subjectivity of the patient when he or she behaves in contradistinction to how normal, medical bodies do. Yet the perspective of the patient is flawed because the patient allegedly cannot “see” his or her own body in a severe state of caloric restriction. Even if the individual acknowledges that he or she is
thin, he or she often does not recognize “the serious medical implications of their malnourished state” (340). The legitimacy of the clinician’s gaze and calculations is paramount over the anorectic’s, and DSM-5’s mention of obsessive-compulsive features, impulsiveness, and alcohol/drug abuse to frame the patient (341) further seeks to entrench this apparent lack of rationality.

The text’s sudden consideration of gendered anorectics is intriguing, not only because it is such a truncated examination, but in that, once again, anorexia in males must be put in contrast with anorexia in females:

The 12-month prevalence of anorexia nervosa among young females is approximately 0.4%. Less is known about prevalence among males, but anorexia nervosa is far less common in males than in females, with clinical populations generally reflecting approximately a 10:1 female-to-male ratio. (American Psychiatric Association, 341)

The question of male patients appears to be a complication that the text hopes to evade by citing lack of research, but it reinforces a convention about gendered eating. While it is conceivable that anorexia nervosa affects fewer men than women, the use of the word “prevalence” is confusing here. The text does not allow for the possibility that males do not seek treatment for a variety of factors including, but surely not limited to, stigma of disclosure and misdiagnosis by their doctors. In her interactions with health care workers, Hepworth has noted that because anorexia nervosa is seen as a predominantly female condition, there may be a reluctance - conscious or otherwise - to locate the condition in males (70). The practitioners in her research repeatedly note that it is rare that a male will admit to an eating disorder, and often offer other interpretations of these men’s symptoms, such as acute depression (71). If the clinic itself is reticent to pair underweight men with anorexia nervosa, this abstention speaks to how eating disorders are codified by inherent assumptions about sex and/or gender performance(s).
Peppered throughout the *DSM-5* are clipped quotations amidst the more clinical descriptions, as if to cite the words of anorexic patients themselves. The anorectics are concerned about being “too fat” (340), they deny a “fear of fat” (340), and/or exhibit “fat phobia” (342). These disembodied voices - both in form and in text - are posed as distinct from the language of the clinician, whose observational vantage point is otherwise privileged. I am curious in how these casual references to a spoken articulation are laced into an authoritative text, perhaps to help achieve a sense of authority. It is feasible that this is how anorectics verbally express resistance to recovery programs, but these quotations reaffirm a vision of neurotic, irrational patients with a lack of insight into their true emaciated forms. This coalescence of *sight* and *scientific objectivity* is reminiscent of Michalko’s point that knowledge is always connected with seeing; that “the less we see, the less we know. This connection is what the work of rehabilitation begins and ends with.” (6) The anorectic is not strictly blind in biomedically scientific terms, but he or she is unable to see his or her body as it *really* is.

The causes and risk factors listed here for anorexia in men also provide glimpses into how the disease is conventionally mapped onto feminized bodies. Whilst the bodily practice of women starving themselves is often attributed to a hegemonic and capitalist culture that imposes an imaginary ideal upon the female body, there continues to be a sense of uneasiness with how to read male patients of the disorder. Anderson has examined how homosexuality is regarded as a “risk factor” for anorexic males in a lot of psychiatric research, and how this stereotype is frequently informed by problematic tropes of “distant fathers, overpowering mothers, [and] gender-identity disorder” (158, 2008). The *DSM-5*’s approach to the development and course of anorexia does not
address gender in this regard, but a “traumatic life event” is posited as a possible cause all the same (American Psychiatric Association, 341).

This is not to suggest that the DSM-5 is oblivious to exceptions and aberrations, or to misdiagnosis of these aforementioned symptoms. The writers allow that “subtype description should be used to describe current symptoms” (American Psychiatric Association, 339; my emphasis), and that the onset and outcomes of anorexia are indeed variable (341). However, taken as a text that instructs practitioners on patients, the lack of attention to the anorectic’s perspective and/or lived experiences is troubling. In the next section, I address how prior research in this field considers anorexia as psycho-pathologic impairment, in addition to somatic manifestation. Furthermore, I complicate the literature in terms of how it assumes an onset-symptom-rehabilitation framework (i.e. a development model of corporeal otherness). Finally, I demonstrate how these studies veer toward essentializing gender and sexual stereotypes about the male anorectic’s body.
Chapter 2: Males in Eating Disorder Literature

*Males with Eating Disorders* (1990), edited by Arnold E. Andersen, is a critical archive in that it represents a relatively early text that addressed male anorexia as a medical and social phenomenon. The anthology includes a considerable amount of quantitative research from professors, doctors, researchers, and psychologists, and it is a valuable resource in unpacking how men are diagnosed and treated as anorexics in the eyes of these professionals and academics. In his introduction, Andersen acknowledges the text is vastly technical in nature (x), but hopes that it will be of use to a broader audience as well. I turn now to an article found in the same anthology entitled “Men, Body Image, and Eating Disorders” by Ann Kearney-Cooke and Paule Steichen-Asch (see Appendix B) as an example of how male bodies present a problem for the biomedical conception of anorexia nervosa. In the study, the researchers posit body image as a crucial element in the interactions that leave a male at risk for developing an ED. The study therefore aims to address “body image disturbance” (55) and the treatments that might mitigate these issues.

The first 112 participants in Kearney-Cooke and Steichen-Asch’s study were culled from introductory psychology courses in a university in the Midwest. An additional sixteen males with eating disorders were recruited with the assistance of clinicians. According to the authors, these anorexic and bulimic men met the minimal criteria described in the American Psychiatric Association’s 1980 version of the *DSM-III*. All men were administered the Body Shape Questionnaire (BSQ), which is a 34-question survey addressing “concerns about body shape, particularly the phenomenal experience of ‘feeling fat.’” (56). Based on these findings, the college students were sorted into the
following categories: “normal” and “at-risk”, the latter of which puts them in line with the eating-disordered patients’ scores. Of particular note is how the BSQ, assumed here to be a fairly valid measure of body image, was initially compiled based on interviews with women with EDs. Kearney-Cooke and Steichen-Asch even add that they “changed the gender where appropriate” in the BSQ, such as in this instance:

Item 9, for example, was changed from “Has being with thin women made you feel self-conscious about your shape?” to “Has being with thin men made you feel self-conscious about your shape?” (56)

The substitution of one gendered body for another, so casually conceded to here, speaks to how male anorectics are routinely mapped onto a treatment system that anticipates feminine (and feminized) bodies. The social contexts that may contribute to formation of body image are also assumed to be virtually the same for all populations. No mention is made of whether the BSQ needed to be revisited and re-informed through qualitative pre-interviews with the ED males themselves. It is also requires the reader to bracket the common-sense knowledge that “shape” is used and deployed in a multitude of ways, with many gender(ed) differences enacted through those uses.

On the subject of contributing factors to EDs (see Table 1 in Appendix B), the researchers offer many possible theories as to why there is variance in body image and eating behaviors across the groups. The usual suspects appear therein, including parental variables (e.g., one’s closeness to his father) and his peers’ reactions (e.g., being a victim of teasing, not being chosen for athletic teams). Even more telling is that the writers employ the Millon Clinical Multiaxial Inventory (MCMI), a 175-item test that was developed “to parallel and complement the DSM-III diagnostic system” (56). This true or false personality exercise claims to assess personality traits, pathological personality patterns, and issues of clinical symptomatology (ibid). And, according to Kearney-Cooke
and Steichen-Asch, “with regard to the personality profile, men with eating disorders score highest on the dependent, avoidant, and passive-aggressive scales on the MCMI” (65). While these questionnaires and assessments could produce credible correlations, the surety with which the authors pursue them as logical extensions is dubious. At times, the characteristics of dependents and passive-aggressive types arguably navigate clichéd waters.

In fact, the ostensibly fluid transition from a “personality” to a “disorder” in the researchers’ perspective is startling. The following excerpt regarding the passive aggressive personality, in a single paragraph, asserts that the roots of such tendencies can be found in familial dynamics and lead to problematic, destructive manifestations later in life:

A distinguishing feature of the passive-aggressive personality is the belief that those who suffer from it were subjected to appreciably more than their share of contradictory family messages. Their eroticism and capriciousness, their tendency to shift from agreeableness to negativity, simply mirror the inconsistent models and reinforcement to which they were exposed. They have deeply rooted feelings of ambivalence about themselves and others. The name of this disorder is based on the assumption that such individuals are expressing covert aggression passively. (65; my emphasis)

Here is a particularly egregious example of how the authoritative objectivity of a true or false personality test can be mapped onto an entire population of bodies. There is an implicit argument that something went awry in these males’ development into adulthood, and that this dysfunction must have then been performed upon their bodies. Kearney-Cooke and Steichen-Asch even later suggest that males who later become eating disordered do not conform to cultural expectations for masculinity, as “they tend to be more dependent, passive, and nonathletic” (67).

Underlining all of this rhetoric is a certainty regarding masculinity and sexuality; that is, the males who adopt the traits of dependent and/or passive aggressive behavior
are more likely to be non-heterosexual. In fact, the authors even assert that all of the 112 participants, who are not eating-disordered, are heterosexual:

Men struggling with eating disorders (Group 3) reported that they were teased more about their bodies while growing up and were preferred less for athletic teams. Their sexual preferences included homosexuality and bisexuality, whereas all the subjects in Groups 1 and 2 reported being heterosexual. (58)

If Group 3’s sexual preferences “included” homo- or bisexuality, it is not discernable whether all sixteen participants identified as such. The vagueness surrounding the sexual orientation of the Group 3 men juxtaposed against the absoluteness regarding the other group’s orientation speaks volumes regarding how we code, even unconsciously, male bodies that are different. The writers do not even question whether the males in Groups 1 and 2 identified as strictly heterosexual for other reasons (such as stigma), or if the word “preference” refers to behavior or identification.

Granted, Kearney-Cooke and Steichen-Asch’s article is a product of its time, but it provides a lens into the scientific language of how anorexia is cleanly historicized and ultimately pathologized for the purposes of study and rehabilitation. This, I argue, continues to be the case with many clinical studies on male anorexics and their experiences. Although the researchers remind the readers that this small sample size, along with the correlational data, must “be viewed with caution” (72), it is unsurprising that practicing clinicians and doctors remain either nonplussed or uninformed regarding the needs of a male anorexic population. If anorexia can be reduced to a fragmented familial history or associated with behavioral issues, then what other histories are being silenced? My contention is that qualitative inquiry is absolutely non-negotiable to tease out more nuanced and participant-centric narratives of lived eating disorders that might do more than reproduce a medicalized understanding of living life through practices that
nurture hunger or other forms of bodily restriction. While this example is taken from a single article in a collection, it demonstrates how bodies that do not conform to ostensibly healthy and masculine practices are automatically classified into abnormal, damaged, and even non-heterosexual categories of difference.

A more recent work, “An Overview of Anorexia Nervosa in Males” (2014; see Appendix C) by Tom Wooldridge and Pauline Lytle, showcases how little the conversation(s) around eating disorders have progressed in the medical community. This literature review cites many of the studies in the aforementioned Arnold E. Andersen 1990 anthology, and by extension, many of the same tropes or theories. The writers isolate “several patterns of family interaction [that] predict the development of anorexia nervosa”, such as overly controlling mothers and absent fathers (25). Conflict about one’s sexual orientation is regarded as risk factor, due to the fact that gay and bisexual men undergo “a cultural pressure to remain thin, similar to the pressure experienced by women” (28). The researchers’ observation that men are subject to a problematic ideal and that body image is shaped by social/cultural factors (27) reads as archaic at this point in time. Still, Wooldridge and Lytle do make a productive remark in that research on anorexia nervosa in males tends to focus on a single etiological factor (30), and they call for a more integrative understanding of the phenomenon.

The association between anorexic males and gay men is not an uncommon consideration in the literature, broadly speaking. And recent papers that I have culled from various journals remain largely quantitative in analysis, tending to focus on arenas of comparison: gay eating disordered men in relation to the greater heterosexual male population, to heterosexual women, and to lesbian women. Although each study focuses
on a different “root” of or subtopic related to the ED (for example, body image, 
childhood abuse, beauty standards, self-esteem, etc.), researchers tend to routinely 
contrast men’s experiences with their female counterparts. For example, queer men are 
persistently read alongside heterosexual women: both apparently grapple with sexual 
objectification and place higher emphasis on physical appearance (Siever, 252). And 
while the prior research has surely included men of color, key issues related to gay white 
culture and sexual racism are not always taken up as significant factors. In making room 
for these claims as what may be well-argued generalizations, I wonder: what is lost in the 
process? What dangers lie in a literature that entrenches such notions upon particular 
bodies? While there is undoubtedly validity in researching LGBTQI individuals as a 
separate entity, in what ways should this be done in the future?

For example, articles that directly study queer men and EDs are quick to point out 
the high correlation between homosexuality and disordered eating and/or body 
dysmorphia, but the discussion thereafter often seems wanting. In one such article, 
femininity and gender role identification are brought up as possible factors, and then just 
as quickly dropped (Russell, Keel, 305). In another article, gay sexuality itself and the 
subculture’s emphasis on “thinness” is attributed to the connection (Carlat, Camargo, 
Herzog, 1131). Then other familiar factors are also considered, such as depression, low 
self-esteem, and discomfort with one’s sexual orientation. However, what if these 
researchers had considered the value of more qualitative forms of data collection and 
analysis? In the themes mentioned above, there are countless complications, off-shoots, 
and exceptions (what would happen to data on a participant who did not fit any of those 
criteria; where does his story fit?). For instance, while I agree that gay culture cannot be
ignored in such discussions, it does not exist as a monolith across the world (nor does it in a nation, city, or town), and is not universally experienced by all homosexual men. Also, if there is a relation between practices of hunger and a particular group culture, how would the movement to medicalize this as a condition-in-need-of-a-cause be a remotely sufficient or nuanced approach?

With respect to men as a general category, the ED literature sometimes zeroes in on “bigorexia”, otherwise known as muscle dysmorphia, and the abuse of anabolic steroids (AAS). Tellingly, a large portion of the literature tends to conflate the term “men” with heterosexual men, unless directly made explicit in the title or abstract. For example, in a study entitled “His Biceps Become Him”, authors Parent and Moradi present the findings in their research identifying heterosexual men as primarily at-risk. While they problematize masculinity as the “criterion variable” for men because studies of gay men show other conclusions, Parent and Moradi also acknowledge that prior work on this type of body shame has largely focused on white, heterosexual men (247). Even in their own study of college men using AAS, the researchers used data from participants who identified as 59% Caucasian, and 2% exclusively homosexual/gay (248). The door always seems to be left open for further research on the other (minority) populations, but the gaps speak to how the methods and data collection processes foreclose the participation of such groups due to the lack of necessary “niche” studies and projects.

The dissimilarity between gay men and gay women is a pronounced theme, as researchers tend to link lesbians and heterosexual males in terms of body image. This is perhaps an unsurprising inference, as the pressures on gay men and straight women are made congruent within the literature. Lesbians may be less affected by their subculture
than queer males, as body shape is not as significant in their definition of attractiveness (Epel, Spanakos, Godley, Brownell, 271). However, there is one argument for commonality between queer men and queer women, in that the shame of same-sex attraction might be a large influence on how the body becomes a site for self-injury (Beren, Hayden, Wilfley, Grilo, 140). This is a refreshing break from the running commentaries on how queer subcultures invariably seem to create toxic environments, as well as from the gendered binaries that run back-and-forth between these groups.

All in all, these familiar tropes and pronounced holes in the literature speak to the paucity of research studies over the last twenty years (and even how the researchers’ notions about anorexia inform and influence how they collect and interpret data). As such, it is my view that additional qualitative papers based on phenomenological studies and life narratives made within the scientific, medical, and academic communities will propel the corpus forward. For my research in this thesis project, I attempt not to assume any categories of interpretation that “should” be important to the participants I speak with, nor do I assume what these categories (i.e., race, sexuality, gender) already mean prior to how they are expressed by the participants themselves. In the next chapter, I present my own data and findings to demonstrate the necessity of this type of research and inquiry.
Chapter 3: Rationale, Methodology, and Data Collection

My aspiration in the data collection process was to elicit the participants’ own language, chronology, and structuring around their experiences of EDs, and to move away from the medicalizing (and often pathologizing) words employed by others who speak about, conceptualize, and treat anorectics. What would a research study of anorexia look like without the words, say, “anorexia” or “trigger” ever once being mentioned by the interviewer, unless first named by the individual? How would the subject describe the act of hunger practices or even self-starvation: as performance, as coping mechanism, or as defiance? And how does this behavior of restriction or otherwise change over time and context, as opposed to being a static and rooted practice? In thinking about eating disorders differently (not excluding disease and self-harm), could we produce more multifaceted and compelling pictures than the images that come to mind when such words are uttered in ordinarily medicalized fashion?

Some examples of these interpretive, slightly indirect questions are represented in the bullet points below. My concern was that immediately discussing the eating disorder might orient the participants’ responses to strictly follow certain narratives they have absorbed from elsewhere (i.e., in treatment, from therapy, from popular culture, etc), or to provide responses that they might have felt I wanted to hear. Once the participants began to articulate an arc around restriction and/or control, I would step in and seek clarification whenever necessary.

- What is your earliest memory of consuming food?
- How did you learn to eat?
- What is your earliest memory of becoming aware of your body?
- What is a healthy body? etc... (see Appendix E for template of interview questions)

Furthermore, what do closer readings of these life histories reveal when these
participants and their bodies are situated against and within larger conversations about the knotted web of identity politics: gender, sexuality, class, disability, and race? When Titchkosky reminds us that “we are never in our bodies alone” (5), it is imperative to explore how anorexia troubles and complicates our coded readings of each others’ physical appearances. What does anorexia do to our understanding of already-labeled corporeal states? And as such, what kinds of particularities are being overlooked in the “one-size-fits-all” approach to treating or defining eating disorders (e.g., feeding programs and group therapy, or causal accounts about the genesis of a medical condition also with no other possible accounts on offer)? How might recovery be perceived and received differently when patients are involved in defining their own notions of healthiness and nourishment, even if those notions radically shake established ones? As opposed to being treated like objects of study (i.e. damaged bodies and fractured psychical minds), what can be done to accommodate anorectics in re-defining their notion of control and agency? Is there a way of engaging with the living of anorexia nervosa as something other than a medical condition?

And, finally, when theorizing, archiving, and considering the act of willful hunger, I wonder if other types of nomenclature - perhaps alterity, defiance, resistance - could be assigned to a practice that is frequently regarded solely as a self-harming disease marked by death, disavowal, and undoing. I make the case for my project’s specificity and future studies on the following grounds:

(a) The lives and experiences of anorexic men are worthy of consideration on their own terms without binary reference to other demographics (i.e., a gender-comparative or sexuality-comparative analysis, as many other studies have tended to be).
(b) Men have been a marginalized and/or misunderstood group within eating disorder research for decades, and require further study.

(c) More *qualitative* work needs to be done in order to account for the exceptions, aberrations, and specificities not represented in the prior literature and diagnostic criteria, and explicitly through the perspectives of these hitherto “invisible” men.

The data was collected in five interviews (lasting roughly one hour in length), conducted between each sole participant and the researcher, and occurred between the years of 2012-2014 at OISE (the Ontario Institute for Studies in Education). All names and identifying markers were altered in the study for the purposes of protecting the individuals’ privacy. As such, all names and references utilized in the study are pseudonyms. The male participants are all in their early- to mid-twenties, many of them students, living in Toronto (although from various ethnic and cultural backgrounds). Each individual was guided through the consent form and informed of any potential risks before commencing with the interview process.

- David (mid-20s; an online magazine editor)
- Kevin (late 20s; a graduate student)
- Sean (mid-to-late-20s; a graduate student)
- Hamza (late 20s; a professional dancer)
- Eric (early 20s; an undergraduate student)

See Appendices D-G for Call-Out Flyer, Interview Questions Sheet, and Ethics Approval Letter & Renewal
Preamble to Research Findings: Methodology and Disclosure

Is there a predictable trigger that produces the willful act of deprivation and starvation? Is this restriction in males linked to the trauma of an absent or abusive family figure (presumably their fathers)? Does anorexia affect homosexual men more so than their heterosexual counterparts? Could these symptoms have been prevented altogether if men did not feel acute stigma in accessing medical care? These queries seemed to be a fixture in my conversations with friends and acquaintances regarding my research. And yet, these theories – well-meaning as they may be – provide key insights into the cultural imagination of anorexia, revealing how medical narratives inform a need to decipher and remedy this embodied alterity. These questions hint at a need for an origin point – if anorexia can be rooted within a chronology, surely its solution is embedded in addressing the “known” contributing factors? Perhaps the condition could have been prevented altogether, had its inception been derailed or avoided.

Yet, this linearity of a developmental and preventative discourse – from the onset of the so-called disease of anorexia nervosa to its rehabilitation – reflects a biomedical rhetoric of same bodied-ness that I wish to employ as a jumping point for deeper investigation and critique. This is to say, I use the nomenclature of “onset”, “duration” and “recovery” (Chapters 4 -6) not to frame (and truncate) the conversation but to explore and – at the same time – ask what these terms mean to my participants. Does the discourse previously mentioned in the DSM-5 and other studies, say, speak to the vantage points of the anorexic males in this study? In creating a narrative of the experience of anorexia, it was key for me to grasp at motifs and repetitions that we are familiar with in our culture, but not seek to entrench them in any way as a researcher.
In this project, the narrative analysis approach allowed an emphasis on the intricate remembrances put forward by the participants. Through addressing the various timelines of how hunger practices manifested in these men’s lives, I concentrate on how the participants each made and continue to make sense of their behaviour in order to contrast the discourse of the aforementioned biomedical literature that confine these *same* practices to pathology in need of treatment. In analyzing the data, I focus both on the socio-linguistic and socio-cultural versions of narrative analysis laid out by Carol Grbich (124). In the former approach, I consider how the narratives of each participant’s relationships to eating changed over time, paying attention to the multifaceted, plural contexts of hunger practices in their lives. In the socio-cultural model, the “broader interpretive frameworks” are considered to signify how gender, race, sexuality, and class are read upon these anorectic bodies (ibid). Both approaches were useful in situating these individual histories against a larger landscape of lived experiences within social power structures.

John W. Creswell’s recommendations for a phenomenological study informed my process, in order to not only recount the lived experiences of the participants and the associations attached to them, but to do so through an *interpretive sociological lens*. In analyzing one’s data, Creswell encourages the researcher to list significant statements from the interview transcripts or data sources in order to create “meaning units”, to write a “textural description” with supporting examples, and finally to create a description of the phenomenon (159). Focusing on the questions of “what” and “how” helped me to organize the transcripts, but this would be a limited approach considering interviews of five participants at this juncture of my research study. With these considerations in mind,
I hope not only to gather commonalities among the statements, as Creswell recommends, but also to closely highlight the exceptions. Although the phenomenological approach asks the researcher to ascertain the “essence” (ibid) of the investigated experience, as a scholar, I am interested in where the theories may not fit. This is of particular importance for me, since the literature on anorexia nervosa is in need of more aberrations and peculiarities to create a richer composite.

My methodology additionally incorporates a hermeneutic phenomenological approach, given my open identification with the participants as an anorexic male. Early on in the planning stages of this research paper, I decided to disclose my experience as a “recovering anorexic” to the interviewees. This strategic positioning presented a variable in the data collection process that I toyed with before deciding to implement, ultimately intuiting that there were more advantages than drawbacks to this confessional approach. As a self-proclaimed “insider-outsider” of the phenomena and as a past participant of an online pro-anorexia subculture, I found ways to provide feedback by affirming and empathizing with the interviewees’ disclosures. I did not always readily begin the interviews with this admission, but found appropriate times to offer commonalities.

I intended for my admission during the data collection process to create a greater level of comfort and reciprocity between the participants and me, not as a legitimization of my identity as an authoritative researcher on anorexia. Rather, I desired for the interviewees to view the overall process as non-clinical and judgmental-free, particularly with an ally and fellow anorectic sitting across from them as they recounted raw and revealing anecdotes. This attention to the inherently interpretive nature of language itself – by both me as the researcher and the participants themselves regarding the subject
matter – mirrors the goal of this project as one of meaning-making, not essentializing, around the phenomena of hunger practices.
Chapter 4: The “Onset” of Anorexia Nervosa in Males

In this chapter, I consider a question that seems to fascinate the observer of an anorectic’s body—how does one develop this condition? Is there a moment in time that it can be located? And where does it manifest? At the point at which a BMI figure for a body falls below the normal benchmark of 18.5, as the *DSM-5* might suggest? These queries not only speak to the cultural fascination with anorexia nervosa as abnormal, frightening embodiment, but also to a collective need to root the anorectic’s practice and appearance in some kind of timeline and causal relationship. In the interviews, I ask the participants – David, Kevin, Sean, Hamza, and Eric – about their relationship(s) to consuming food, and when they became *self-aware* about changes in their eating habits. What emerges in these discussions is a truly revelatory picture of how male anorectics understand their hunger practices, and whether contributing factors or pathological personality patterns have any legitimate bearing on how anorexia comes to manifest (as the prior literature has strongly suggested).

David’s experience of extreme caloric restriction began following a “hedonistic summer” in 2006. He recalls feeling uncomfortable in his body comparing himself to his roommates, and could not look in the mirror without fantasizing about being thinner:

DAVID: My one big thing was love handles. I was obsessed with getting rid of my love handles. So, I’d always considered myself to have somewhat of a womanly body. You know, I would always see... I wasn’t fixated on men with muscles, or men with big, y’know, musculatures. It wasn’t never about me being built. It was more about me being *fine*. Fine, like a stick. You know, like, I wanted to be as thin and... I used to say empty. I wanted to be empty. So I wanted to have no... muscle. I wanted muscle, but I wanted to be lean. So, I kept saying I wanted to be empty. I wanted no food in my body. I wanted no muscle on my skin. I wanted to be as... I wanted to be as fine as I could be. Like a ballpoint, like a fine pen. And uh, as much weight as I lost, I never lost those love handles.

Particularly notable in this excerpt are the varying and gradual degrees of David’s
corporeal effacing. David first finds displeasure with a particular body part (“my love handles”), and then moves to tentatively comparing himself with other men and women, not settling on either as a desirable reference point. “Muscle” seems to be a loaded term, because it does not suggest an aspiration to be “built”, but rather for a specific leanness. And then, just as abruptly, David aspires to not having any muscle at all, but being empty, without food, as “fine” as he could be, using the image of a pen. This fits with Anderson’s reading of the emergence of anorexia as “a certain kind of becoming, a becoming that is itself an undoing” (32, 2010).

“I never considered myself to have an eating disorder,” David adds, who spent three months in an in-patient symptom-reduction program at Ottawa General Hospital during early 2007. He did not seek treatment himself, but credits his mother for intervening and “sav[ing his] life” by calling dozens of hospitals to ask if they would admit him. Tellingly, the words “control” and “diet” are more descriptive of his routine; in retrospect, he does understand the experience as anorexia nervosa now, but prefers not to see it strictly as a disease. Rather, he “got addicted to not eating food” or “addicted to numbers”:

DAVID: I felt it was a numbers game. And I could never win. The more I… the fewer calories that I could imbibe, the more weight I lost […] And the faster I cut those calories, the more weight I lost. So it was all about math, really.

The compulsive behavior that other people saw as disordered, I just thought I was restricting. But not in that word. I mean, the word now is associated with eating disorders, but I was restricting in the sense that I knew approximately how many calories I needed in order to lose one pound. You know, thirty-five hundred calories is one pound.

David even evokes how the BMI scale was important in his own tracking of progress, going from 22 to a low of 13-14. Looking back, he does not pinpoint a specific trigger for why he began to restrict, other than feeling a need to lose weight. He admits to having “a
very compulsive personality”, and that this attention to numbers was a ritual that consumed his time outside of his job at a bank.

David’s narration reflects a need to grapple with many different chronologies (I will speak of his relapse with bulimia in a subsequent section), which reflect the slipperiness of the language we employ around anorexic embodiment. Whereas he articulates wariness around the terms “anorexia” and “eating disorder”, he also refers to identifying with “a disease that mostly women experience” (my emphasis). He frames his previous fear of weight gain as “irrational” because his “brain wasn’t working properly”, yet suggests that his diet back then was based on a rather straightforward and logical addition-subtraction formula (for example, the restriction began with the simple act of cutting desserts out of his diet). His in-patient treatment has also clearly affected his narration, because this experience has delineated his analysis of his anorexic practices pre-and-post hospitalization. Although David later complicates the notion of being recovered, his bouts with anorexia are labeled as, fundamentally, a lack of “control” in his life that manifest(ed) in restriction or binging.

Kevin also uses the words control and it in his account, and the terms are similarly deployed in multiple, tangled ways. He discusses an early practice of “controlling portions” and making himself vomit, because “it is about control”. While he does not pinpoint a particular moment that his eating habits shifted drastically, “it’s always sort of been there”. The reference to it refers to the impetus behind eating disorder itself, but Kevin adds in the same breath that “now, at 29, it’s only that I have some semblance of control and healthiness about it, you know?” (my emphasis). Here, control encapsulates both the practice of restriction, but also the managing of that very restriction. Despite
Kevin attributing the first type of control to cope with a difficult break-up with a girlfriend in his late teens, he remembers being told at an early age that he was chubby “and not liking that”. He also attributes this early awareness of his body to being raised in an East Asian household, in which it is a “culturally accepted thing where the first thing that they say to you is that you’ve either gained weight or you’ve lost weight.”

In a sharp contrast to David and Kevin, Sean characterizes his eating habits as a cycle of adhering or not adhering to “healthy” patterns. During the course of our interview, he did not bring up the words “control”, “anorexia”, or “eating disorder” at all. Rather, Sean was more comfortable narrating his history of eating as being “careful”, as in the following excerpt:

YASEEN: And maybe compared to your brother, would you say you had similar eating habits?

SEAN: No, no. My brother had much healthier routine than me.

YASEEN: What do you mean by “healthier”?

SEAN: Well, for example, like, whenever we had a meal, I ate much more than he did. You know, like, he didn't eat too much but I occasionally ate too much. And even like taste preference, I think I eat more, well, I guess I like oily, like salty spicy food than he does. Something like that.

YASEEN: And when you occasionally ate too much, like you said, how did you feel after?

SEAN: Well, like, oil is delicious, but I ate too much. I can't move, I ate too much. Sometimes, a little hard to breathe.

YASEEN: So physically, you felt negative, you could say. But what about guilt? Would you say that's an accurate description?

SEAN: Guilt, like… I'm not sure if I should feel guilty about it, but I certainly felt that um… "Oh, I ate too much. I should be careful next time." Because eating too much is not good for my health, so I should be careful next time. I think I had such thought.

YASEEN: And then the next time, were you careful?

SEAN: Yes.
YASEEN: So if you were to be careful, what would that look like? Just eating less, do you think?

SEAN: Eating less, and like um… eating less and eating more vegetable than like how much I used to. And reducing oily salty thing and eating more regular pattern. Regular pattern.

It bears mentioning that Sean does not speak English as a first language. This does not in any way diminish the validity of his statements, but I am mindful – as an ESL educator– of how the varying levels of ambiguity, abstractness, and complexity embedded in questions are interpreted by participants. That is, I wonder: was Sean’s sidestepping of the clinical and cultural language of anorexia a conscious choice? When he sometimes responded to a question with “I can’t get into more detail than that, too hard to explain”, was this a reflection of his current vocabulary abilities in English? Or an intentional disavowal of anorexic practice? As I have stated before, my aim was respect and follow the discourse that my interviewees felt comfortable articulating, and it is an issue worth revisiting in subsequent research by me or other investigators.

When Hamza is asked if there was a particular moment where he became acutely cognizant of his body, he easefully transitions into a timeline of dates and years. He recalls a remark directed at his body as a turning point:

YASEEN: So I'm wondering, was there a moment you understood your body, where you had that self-awareness about the way you looked? Do you have a certain point in your life where you started becoming more aware?

HAMZA: Absolutely. [laughs] On some level, you're always aware about your body, the way it works. But you know, because of the environment you're in, because of the community and the people you interact with on a regular basis, you just… it becomes a secondary thought. But I remember it was Thanksgiving of '99, uh… yeah. That's when I, uh, it was right after lunch. We were sitting with our family friends, whose… And the mom in that household was my Urdu teacher for a very long time in high school.

And I remember her remarking - making this really, really facetious remark that I had actually lost weight, when in fact, I had actually gained about ten pounds since she had last seen me. Um, and at that time, my mom was completely caught unaware. This was
the first and the last time I think my mom has actually been very, very… I actually heard my mom actually being very, very frank about what she thought about me, in terms of my physicality. And she said, "Are you kidding? He's actually gained a lot of weight, it's unhealthy how much weight he has..." And that's when I realized, that "Yes, indeed, I have actually gained weight." I actually have a lot of bad eating habits. And, um, yeah. I think ever since - the next day, actually, the next day in the afternoon is when I started to become very, very aware of the way I looked. And the way I dressed, the way I… I mean, I started judging myself of that moment.

Hamza shows how family dynamics inform both rituals of eating and of self-image, particularly in the severity of his mother’s seemingly flippant aside. He began portioning his meals, drinking more water, and exercising regularly – all of which resulted in a loss of forty pounds over the year of 2000.

However, Hamza later experienced a more drastic, “unintentional” drop in weight, after falling sick during a trip to India. When he returned home to Canada, he realized that he had gone from 140 pounds to 126:

HAMZA: That actually caused a few health-related issues. I would get constant pains in my upper back because of lack of cushioning and stuff like that. I was suffering from low blood pressure as well, and you know… you come in at 126 and then when you end up falling asleep at 9pm every night, it's just wrong.

And I began to feel it… and especially… my brother and I have a very interesting relationship. We're so friendly sometimes that we end up fighting with each other, like physical fights. Uh, it was when I had actually partially dislocated my right arm was when I said "Uh oh, something's not quite right here. Uh, something needs to be done." So yeah, I actually started eating a little more at that time. And then when I reached 130, I figured… that's my goal weight, so I should stop right there.

Hamza’s self-awareness about the somatic vulnerability of his body, coupled as it was with a euphoria at reaching a low weight, challenges the DSM-5’s claim that anorexics “frequently either lack insight into or deny the problem” and that outsiders are better able to evaluate the progression of the condition (American Psychiatric Association, 340). Hamza actually attempted to gain some weight back and settle on a number that allowed him to retain control over his hunger practices and his well-being.

Eric, in his reflections, closely connects the passing of his mother to the start of his
fasting ("[I] became – I feel I became – anorexic after she died"). His mother, who had also struggled with weight, was unable to eat during the last three months of her life, being in the final stages of pancreatic cancer. Eric, who had laboured to lose weight before, succeeded after his mother died, he says, “for whatever reason, … as though I had more willpower or coping to some response to that”. He offers the following insights into his control:

ERIC: So over the period of late August 2007 to early December 2007, um, my body weight fell from 165 pounds to 115 pounds. And I know that my BMI was under 18.5 for what my height was. Um. Not that that means a lot, I know that they're problematic, but I also know that they're the language that they communicate it in. 18.5 as the benchmark – like, that was the goal. That was how I looked at the BMI chart. I was like, “Ok, so 25 is bad acceptable and 18.5 is good acceptable.” So problematic. Um. It’s how I understood it.

Eric is clearly critical of the BMI scale as a litmus test of healthy vs. unhealthy bodies, but acknowledges that it was a key resource for him to track his progress. Since he admits he could not use photographs to know if he was indeed achieving his targets, this appropriation of the clinic’s inscription of anorexic measurement allowed him to know that he was truly underweight because he could be quantitatively (and legitimately) marked as underweight.

Crediting on-line sites and smartphone apps in informing him about calorie-counting and weight loss, Eric kept dropping pounds until his father intervened out of concern. Ultimately, despite being pushed to see a doctor for his symptoms, Eric actively diagnosed *himself* as anorexic, not his health practitioner:

ERIC: [My father] sent me to the doctor again. I had a different doctor this time. I wasn't a kid anymore, so I couldn't see a pediatrician. I had formerly seen a pediatrician, because I was under the age of eighteen. Um, the family doctor's also my dad's doctor. He's really good. But he didn't pick up anything. I didn't wear ankle weights this time, but I did consume a lot - like, it was an insane amount of water. I just, I remember it so distinctly. Um.
Before he weighed me -- he didn't pick up on it though. And I think I was around 18.5, or under it, um… I did have clothes on, and -- not shoes, but clothes on, that would have changed it. Um. He didn't do anything. He diagnosed me as having anxiety. Um, I just knew I was really unhappy during that time, but I didn't have any symptoms of depression. I didn't have too high energy, so he swung the other way, and diagnosed me with anxiety.

[It’s] weird thinking back, I wouldn't have said I had anxiety… I have friends who are diagnosed, and I'm, I'm too different. My experiences were too different, but I was able to… he did prescribe anti-depressants, also because, they're simultaneously anti-anxiety.

And I was seeing him a lot, uh, for just check-ups. Um. And then eventually, I realized "No, I have anorexia", and I just said flat-out to myself "I'm anorexic." And then he just - interestingly, he didn't debate it, he just, he accepted it, based on my own diagnosis. Um. Which I mean, I was - I met the diagnostic criteria, too, so it wasn't just my diagnosis.

This anecdote speaks to Hepworth’s observation that men continue to be misdiagnosed, being treated for depression and anxiety as opposed to anorexia (71). Eric was able to “meet the diagnostic criteria”, according to the BMI, which legitimately put him into a significantly, lower-than-normal category as per the DSM-5 (American Psychiatric Association, 338). Following this diagnosis, Eric was then referred to a nutritionist for support and signed up for meditation classes as part of his recovery.

For most of the interviewees, caloric restriction was coded through a practice of “control”; other than Sean, all participants spoke to understanding their practices as highly regimented, numerical calculations. However, the reasons for why the men began to restrict calories or fast are various and clearly do not fit into the parameters set by the surveys and personality tests I reviewed in prior studies/literature. Arguably, the participants seemed to have varying levels of self-awareness about their practice as damaging to their health, even as they chose to continue with those same weight loss strategies. Not all of the participants experienced a traumatic experience, other than Eric who marks the death of his mother as a major life event, and Kevin, who experienced the
end of a relationship. All do, ultimately, recall that their restrictive practices began with a state of discomfort around their bodies, namely seeing themselves as chubby or overweight and doing so through the eyes of others. Thus, locating onset in a *relational* manner might lead to different discussions of symptoms and causes than medicine usually allows. Also, if that onset is narrated through relations, this might make anorexic treatment programs pay attention to themselves as not just “help” or intervention but as one *in a relation* with the onset of anorexia.

**A final important note:** On the subject of sexual orientation, I balk at including of a discussion here since, for one, the interviewees were never asked to disclose it, and it was not a direct query I pursued (or wished to address) in the data collection process. More importantly, since homosexuality has long been regarded as a “risk” factor for anorexia, it was my hope not to reduce the participants to strict camps of identification in a study that was about free association. However, it would be remiss of me not to address this aspect since for some participants in this study, it was imperative to strategically position themselves as *heterosexual* to shed light on how straight men are sidelined in medical and cultural understandings about anorexia. This seemed to be the case for at least two participants – David and Kevin reflected on how their heterosexuality troubled others’ readings of their appearance and behavior.

During my discussions with Sean and Hamza, neither participant directly addressed his sexual orientation. Eric openly identified as homosexual during the interview, recalling how he “came out” to his ex-girlfriend about being gay and anorexic on the same day. We discussed his opinions regarding the question of whether gay culture and body standards influenced the development and timeline of his eating disorder; his
feelings on the matter are covered in the next section. Broadly speaking, it is not my impression that an exploration of homosexuality and bisexuality in studies about anorexia is unwarranted and/or taboo. Rather, it is the manner in which prior literature has implied correlation as causation that needs to be troubled. Data collection around sexual orientation should not be restricted to a checkmark, but elicited around a richer narrative of the familial, social, biological, lived, corporeal, and elements that inform an interpretive qualitative approach.
Chapter 5: The “Duration” of Anorexia Nervosa in Males

In this section, I address and gather the ways in which the participants discuss how they live(d) with anorexic practices, particularly how they did or do so within a culture does not know how else to comprehend their bodies other than as sickness and abnormality. What is of significance here is each interviewee’s commentary about masculinity, and how their anorexic embodiment challenged others’ perceptions of them as men. Other subjects that were brought up included the men’s interactions with doctors, caloric intake, and especially the notion of “control”. This is a word that most of the participants seemed to deploy, but also with particular reservations or asides. Indeed, language’s ability and inability to express the experience of anorexic embodiment harkens back to my comment regarding Creswell’s boundaries around a phenomenological approach that grasp at an “essence” (159) of experience. Instead, what I am most intrigued by is how each narrative is informed and complicated by sociological factors such as language, gender, race/ethnicity, sexuality, class, etc.

David experienced anorexic embodiment at its most pronounced while enrolled in a hospital in-patient program with five other women. What is most compelling about David’s narration is perhaps his recurring identification as an anorexic heterosexual male, and how he embraced being, in his words, something of an aberration. In this moving extended excerpt, David speaks to gender performance, experiencing a sense of solidarity with anorexic women, and “using his body as a weapon”:

DAVID: [When] I was in hospital, it was obvious to me that I was utilizing and employing my feminine proclivities, in the sense that not only did I look feminine, you know, in the sense that I had no muscle on me at all, but I started piercing my - this is when I started getting a lot
of piercings - so I pierced myself. Um, I would wear nail polish. […] I started wearing, like, tight shirts as well. And I generally, I had no facial hair because my hair stopped growing. So I looked extremely feminine. And this was very eye-opening for me, because I had shut off my emotions for the last six months to anything. I - I wasn’t laughing, I wasn’t smiling. And I, for the first time in my life, probably acknowledged the fact that I have some - despite being a heterosexual male - I had this unspoken femininity to me that was being explored. And at the time, I wasn’t feeling sexual. I hadn’t felt any sexual feelings for months. You know, I - there was nothing about myself that conveyed anything, you know. I’d never, in the hospital, I never felt - around these girls - like, I would have, perhaps, if I was, you know, well. But I definitely explored that part of myself. And there were, I was in a main hospital, I was on the main psych ward. So we shared a psych ward with the rest of the hospital. So there were men in there, like, people with schizophrenia, people with bipolar. I was interacting with other men. But I was very much a part of the women.

And I say this because I used that, I used my appearance as a, as a weapon, in a way, you know, I was one of the girls. I was part of the, I was part of a team in a way that I never had been with guys. ‘Cause guys are very much loners. They’re very much, what, you know, as a guy, you’re expected to be self-sufficient. But with girls, it’s - especially with, with, with these girls, who were mostly damaged in some way. We stuck together. We talked about everything together. We were companions. So, in that sense, I think, I think, from the beginning, I was so alone in my actions. You know, I restricted. So I withdrew from people. I withdrew from my friends. My family. Withdrew from my interests, my school, my work. And there were no, there were no male influences in my life at the time… And after a while, my identity coalesced with that - I became the guy with anorexia. For a long time. And it helped me, it helped me define myself in some way.
His comments on appearing and behaving more “feminine” echo Anderson’s claim that male embodiment of anorexia is an affront to expected gender norms:

[M]ale anorexia represents a category of cultural practice that works against the conventional masculinity anticipated for men and enforced at the site of the male body, representing both the gendered nature of modern medical practice and an insistent, if dangerous, mode of resistance to cultural expectations for how differently gendered bodies are compelled to consume. (Anderson, 155, 2008)

David clearly has adopted the notion that male anorexics, particularly heterosexual-identified men, are a minority population. But at the same time, this corporeal and philosophical liminality enabled him to find a sense of community with his female peers and to disrupt a masculine appearance by way of his unmuscled (perhaps emaciated) body and other adornments that marked him as “feminine”.

He does not think of himself as a “victim of anorexia”; rather, he sees this difficult time in his life as one that allowed him to identify and empathize with women (and even gay men). Still, David once again returns to the idea of control, because unlike an addiction to alcohol or drugs, there is no choice but to eat food. Looking back, he essentially regards fasting as a coping mechanism for dealing with a loss of control in other areas of his life:

DAVID: The disease and the, um, the basis for the circumstances surrounding it may be slightly different for men and women and maybe slightly different for gay and straight men and women, but fundamentally, it is about control. It’s about “I was out of control in a lot of other aspects of my life.” I couldn’t deal with school and work. I hated them both. And the only thing that brought me any satisfaction, any, uh, joy at the beginning was restricting. And that was the basis for, for every person I met - it was all about control. Regardless of age, regardless of gender. And in that sense, I was very similar to a lot of them. It just so happened that I was male and I was straight.
This notion of control or loss of control is a key in what David calls a “second stage” of an eating disorder, bulimia nervosa. He “went from one extreme to the other quite quickly” following his stay at the hospital, gaining weight to the point where he says he was unrecognizable to people in his life. At the core, though, the same feelings were there – “of insecurity, of self-flagellation” – that were present during his anorexic practices.

Kevin, in our discussion, rejects a lot of the rhetoric that locates the roots of eating disorders in the pursuit of an impossible aesthetic ideal, and then holding oneself against it. Dismissing this as a “surface level analysis”, he finds more credence in an understanding of anorexic embodiment as a self-purging; that is, not a literal disavowal of food through starvation or vomiting, but a purging of oneself:

KEVIN: I think, for me, personally, ‘cause I can’t speak for anyone else’s experience, but it wasn’t a question of actually purging. It was a question of purging oneself - like, that was it, right? And for - when I was... starving myself, it was never a question of thinking this would actually work. It was appreciating the feeling of hunger. You know, I think, I remember very acutely that sensation of when you don’t eat, and your stomach does that suck-in thing. Right? That sensation of feeling the skin brace itself against... um, flesh.

Challenging the notion of the anorectic as a passive victim, Kevin understands his fasting and purging as operating from a space of resistance. For him, the anorectic is not strictly a food addict who denies, binges, and/or purges, but engages in the practice for deeper social reason(s). Namely, that he or she is invested in his “self-destruction” in relation – or opposition – to society itself.

In a curious turn, Kevin uses the analogy of smoking cigarettes to elaborate on this notion of defiance:

KEVIN: Well, I think that’s what happens with smokers. I think that ultimately, you like the fact that you’re a social pariah.

YASEEN: Mmhm.
KEVIN: Yeah, are you kidding? It’s, it’s... you can’t think of these things as simply... because it becomes intertwined with you. And I think that, like, yeah. It doesn’t operate simply as something that, “Oh, this person is sad”. I think it does operate from a space of defiance, right? Like, for me, it was... and I stress this, this is, this my take on it, right, because it’s very particular to everyone.

YASEEN: Yeah.

KEVIN: I grew up in a very strict - not strict - but... Particular ideals of masculinity were imparted upon me from my father and grandfather. I mean, and I could never fulfill those. I mean, I do... in some respects. Um. But I’m working class, dude. You know, my background is fundamentally that. My dad’s a tool- and tile-maker, so is my brother. Most of my uncles work in the automobile industry. Um. And I don’t drive.

And I say that to stress certain things, where it’s like... [sigh] We use these things - [pause] It’s, it’s sad - but, I think, in relation something that tries to mold us into something else, we use our pain as this way of actually... you know, demonstrating our strength. Because it would be way too simple to actually say that this is just a question of self-hatred. It’s... some of it is there, no one’s precluding that. But I think that really it’s like... it goes much deeper than that.

In struggling to render the complexity of this idea, Kevin beautifully portrays the slippage of lines between destruction and defiance, self-hatred and outward rage, agony and agency. That intertwining of it with you speaks to how anorectics are embodying two opposing forces in contradistinction, what Anderson narrates as “resistance to an outside force, but a particular kind of resistance that imagines the death of the subject as its potential final effect” (9, 2010). This pain Kevin alludes to, performed as a display of strength, is turned upon the body itself as a violent, staged intervention against systemic norms and powers – what could be termed “larger institutional and ideological domains” (Anderson, 3, 2010).

Heteronormative (i.e. normed, heterosexual, expected, often accepted as healthy and depicted as desirable) masculinity is one of these domains that almost all the participants seemed to be problematizing in their anorexic practices, whether consciously or otherwise. Similar to how David relished in using his body as “a weapon” to disrupt
gender norms, Kevin also seemed to be resisting particular scripts handed down from his father and grandfather. In discussing “coming out” to his parents as eating-disordered, Kevin also speaks about how “it was so confusing for them…, for any number of reasons, culturally, ethnically”. He recalls even visiting a doctor at the Hospital for Sick Children in Toronto, who rolled his eyes when Kevin mentioned the possibility of dealing with an eating disorder. Similarly, Hamza speaks to how, in his family, weight loss in males is regarded as undesirable and even baffling; at one point, he describes developing migraines from excessive fasting and exercising, and…

HAMZA: …my dad, being my dad, used that opportunity to immediately say "You see, you tried dieting and now you're gonna get headaches." I didn't know they were migraines but they were migraines. And uh, yeah, so he would try to get me to eat a lot more. And I still would push back and yeah. […]

People who used to be most… people from my grandfather and grandparents' generation who would be very, very averse to this weight loss. Yeah. "Only women should be this thin. Why are men being this thin?"

This resistance to familial expectations is not something Hamza would verbalize as a political stance of defiance, at least not at the time of his practices. He did not even consider himself to be anorexic during his lowest weight(s), despite recounting an anecdote in which he attended a workshop on eating disorders, and saw himself reflected in the symptoms listed:

HAMZA: [After midterms], I was walking along the corridors [of my university] and my friends were with me and we went into this room where they were having this workshop. And interestingly enough, it was a workshop on eating disorders. And I went there and read the symptoms for anorexia, bulimia, and a whole other bunch of disorders and… even though anorexia was the one that hit home the most, I just kept telling myself, "That's not anorexia at all, I'm not a girl." Really? In hindsight now, I feel like that's the stupidest thing to tell yourself: "I'm not a girl, I don't get anorexia." […]

It’s a coping mechanism, you never want to admit to yourself that you’re there. You always say that “No, I’m in a much better position, because it’s me. I don’t qualify with the rest of the people.”
Notwithstanding this, Hamza does admit that it the materials did have an impact on him: “You take it and keep it somewhere in the back of your mind, and it kind of, you know, rears its head every so often to remind you it’s still there. But you keep denying it…” This raises a key issue: does resistance needs to be understood as such by the actor? It may even be the case that the person may not even consciously intend for their actions to be read as such (Hollander, Einwohner, 543). So, although Hamza seemed to first divorce himself from identifying as anorexic, he certainly was aware and appeased that his appearance unsettled his family members.

Eric similarly engaged with medical and psychology literature on anorexia during his restrictive periods, and found it to be “overwhelmingly female”. This may be the reason why he, at one point, did not think of himself as anorexic, since males were apparently not high-risk for the disorder. Still, after his father intervened, Eric realized there was an illicit quality to his practices that differentiated them from dieting per se – that even though he liked what he was doing, he appreciated that it “wasn’t right on some level”. However, he is wary of employing the word “control” to precisely describe his practices, because, upon contemplation, he views the need to control as the crux of the issue or problem (i.e. what he and other participants in the study have repeatedly called “it”):

ERIC: I remember I would think in terms of the illusion of control, a lot, during the year that I was in recovery, that I would-- I understood that if I thought I was gaining control, I wasn't actually in control. And that it was actually something that I needed to get over that was making me do that.

YASEEN: Mm-hm.

ERIC: And there was a shift when I actually understood that -- the problem was the condition, not what the condition was making me think was the problem.

YASEEN: Can you tease that out, a little? Do you mean the problem being food?
ERIC: No, the problem was… how do I phrase it? Ok, the condition made me think the problem was food or my body.

YASEEN: Right.

ERIC: And it was understanding that thinking that that was a problem was itself the problem. And always trying to intervene, and render it technical, was the problem. And thinking I had control. And that was the illusion of control: that by trying to control, I lost it.

Indeed, control is a key word for most participants, but it obviously seems to lack the appropriate nuance here. Eric adds that there was a moral, superior quality to his fasting – although he enjoyed a boost of self-esteem in his body image, he acknowledges that there was an “ethical” and “moral quality to it”, especially when he placed himself in competition with others’ physical sizes. Similar to David, Eric’s gaunt body presentation was personally significant, particularly by way of wearing tight clothing and seeking external feedback.

After Eric casually disclosed his homosexuality early on in the interview, I asked him what he thought about the theories arguing that gay men experience higher rates of and prolonged bouts with eating disorders. He can appreciate the theory on some levels, but asserts he did not “participate in gay culture” during his fasting. And although he admits having had exposure to gay pornography, he was aware even then that the actors in such films are “not remotely representative” of men’s bodies. Still, he offers the following thoughts:

ERIC: I mean coming out, what it became connected in was just a lot of the more learning to define myself, learning that my culture could be immeasurably fucked up to begin with, and that, um… I wasn't at fault for defined, arbitrary benchmarks of what I should be. […]

I felt really lucky that I went through recovery before I made a lot of gay friends and went through a lot of gay culture. Um. Because while it may not have been a factor, uh, in my experience, but I learned what to watch out for in terms of what was problematic. Like, in recovery. And realized that I felt people - the community -
needed recovery way more than I do on more than one occasion. In comments they would make about other men, how they construct other men's bodies, in terms of how they would just themself, what it was socially acceptable to say.

Gay culture then, for Eric, places problematic expectations on queer men’s body presentations, but he does not lend credence to the notion that it is a determining factor for developing “disordered” eating practices.

What most participants share here is a sense of how language struggles to encode the rationale behind and performance of anorexic hunger. This is a particularly cumbersome feat, considering how many timelines and political standpoints each interviewee has tried to render in his storytelling. The word *control* has a stalwart presence, but the males seem frustrated with it all the same, hoping to unearth a drive fueling said control. What stand out are the unsettling visuals and pronouncements of anorexic practice. There are hints of morbid articulation of both opposition and self-effacement, enacted at the site of the body, in terms of David’s weaponized, gender-queer physique or Kevin’s literal and metaphysical purging of himself.

As Anderson reminds us, “the meaning of self-starvation oscillates wildly between perversity and pleasure, devotion and resistance, hope and despair, love and loss” (2, 2010). Perhaps what these men show us is that the true impetus behind anorexic hunger is a liminality that resides in between this vocabulary, untouched by language. Still, anorexia continues to be expressed in a clear diagnostic (usually non-poetic) discourse, via parents, doctors, workshop literature, hospital orders, etc. What is “restricted” and hyper-controlled then is the medical and public language used to express “what” anorexia *is*, admitting little of its actual life and presence in anorectics’ day-to-day lives.
Chapter 6: The “Recovery” from Anorexia Nervosa in Males

Recovery; rehabilitation; survival: a set of loaded terms, particularly in the context of how disordered eating is characterized as a physical disease and psychopathological disorder. Either these battles are seen as fought and won, by “survivors” of anorexia and bulimia, or they are lost with the sad stories of those who succumb(ed) to these illnesses. Articles, stories, and anecdotes about anorectics tend to be littered with this terminology, but they seem inadequate in their gestures toward a finality, whether life-affirming or sombre. Are these even words that anorectics – recovering or otherwise – even subscribe to in characterizing their experiences? Yes, the interviewees in this study largely understand themselves to be recovered, in some sense of the word, yet anorexia nervosa still informs their eating practices and their outlooks on self-image and control issues, as we shall ascertain from the following narrations.

While David cannot fathom restricting like he once did, he is wary of ever identifying as entirely recovered:

DAVID: … I don’t think anybody with anorexia, has... can say they’re ever going to be fully recovered, ‘cause you can’t not eat food. You know, you can... That’s the distinction that a lot of the doctors made about, you know, about anorexia or an eating disorder as an addiction, is that if you’re a drug addict or an alcoholic, you, you cut those things out. You never touch them again, and you can live a very normal and happy and healthy life as long as you keep to your ethics and make sure that you’re diligent about, you know, staying away from the wrong people and, you know, not giving into temptation. You have to eat, there’s no choice. And that’s scary, because it’s the very drug that leads you to do these things is the one that keeps you alive.

Recalling his experience of bulimia, of going to “the other side”, he acknowledges that he is still self-conscious about his weight. But reflecting on these two extremes of anorexia and purging as “self-destructive”, it seems as though David has adopted discourse around managing addiction – as evidenced by his inverse analogy here with
drugs and alcohol – to help him make sense of his temptation to restrict. He even credits his in-patient treatment doctors with helping him gain this insight.

Kevin also underwent extreme weight gains and losses, from anorexia to bulimia, and from bulimia to “bigorexia”. Today, he appears to be muscular and toned, but he confesses that these sudden and stark physical changes have made him sensitive to how others perceive him: “I’ve been misread so many times that I’ve developed a complex, like, a series of complexes about it […] Embodiment is a weird fucking thing. And then people just take you up and raise you and take out however many issues of their own on you.” This observation speaks beautifully to Eli Clare’s conceptualization of bodies as central to an anti-oppression politics, namely that they should not be abstracted from the conversation of combating systemic inequities:

Locating the problems of social injustice in the world, rather than in our bodies, has been key to naming oppression… But at the same time, we must not forget that our bodies are still part of the equation, that paired with the external forces of oppression are the incredibly internal, body-centered experiences of who we are and how we live with oppression. (360-361)

Kevin regards masculinity as a “perpetual performance of insecurity”, which by his own admission may explain his current fixation with becoming larger and gaining muscle mass, but he admits that he still “hate[s]” his body. Therefore, while he may appear to be a model for nutritious and recovered eating, the same discomfort that instigated his initial practice of hunger acutely lingers.

When directly asked if he has ever been pressured to lose weight due to his occupation as a professional dancer, Hamza unexpectedly claims the very opposite. One of his choreographers instructed him to eat more and build muscle due to the physical challenges of the performance medium. “[D]ance has actually helped me very much building a better image of myself in the sense that I don’t deprive myself,” he is
relieved to say. When asked about the difference between being anorexic and being recovered, he narrates a journey from lacking in self-love to coming to terms with oneself:

HAMZA: Recovery means going through a process of actually maturing and as I said, self-acceptance… When you don’t love yourself, you have low self-esteem, because that is also something that drives anorexics. Or at least in my case as a former anorexic. Low self-esteem was a big, big factor… So coming to terms with yourself and then living your life the best way you can in a healthy manner, in a way that serves you, become a better individual… that’s recovery

And making your peace with food. I haven’t been to a gym in six years. It’s entirely dance.

Still, he admits the fear of “once a fat kid, always a fat kid” keeps him in check regarding healthy choices. Once again returning to the importance of family, he mentions that inner thing that makes him think “You’re gonna have to give up into your genetics and become fat again.” While Hamza appears to embrace the recovery model, he does admittedly have to monitor himself to make sure that he does not overeat or begin restricting again.

Eric completed two programs as part of his out-patient recovery for anorexia (working with a nutritionist and attending meditation classes), and he reflects upon what he found beneficial at the time. What is fascinating about this treatment period is that he began bulimic practices as a way to resist gaining weight. “I ate a lot of food, because my body was really starved,” he recalls, “but I also really hated eating food, psychologically, cognitively. So I developed habits of making myself throw up.” It did not help matters that he found the nutritionist “intensely intervening”:

ERIC: I didn't find she gave me the right tools. Um. I also don't feel I was completely honest with her… But then eventually, my weight, it was steadily increasing that year. Um. And then, on my own, just based on a comment she said… There's in, you're probably familiar with the intuitive eating model within the recovery community. I came across that information myself: "Ok, this makes a lot of sense, I'll implement it." And that just basic- my problems of stressing over
Recognizing when he experiences hunger is how Eric has re-learned to eat; still, he troubles the word “recovery” because it can still be based on calorie-counting and the BMI scale. At this time, his definition of recovery attempts to reject “constructed, imposed obligations” by others.

Eric admits that he has returned to bulimic practices since completing these programs, which demonstrates the non-linearity and non-temporality of how participants may contend with a recovery mindset. He reveals that in the spring of 2013, his nutritionist asked him to speak at a panel during a conference on eating disorders. She was proud of his progression and wanted him to participate as a recovered patient, but in an ironic twist, Eric binged and purged after the talk: “I thought it was part of the performance of recovery to her,” he marvels now. He acknowledges that reversion is always possible, and paralleling David’s comments earlier, that the anorexia requires “maintenance”. What is different now is that he no longer fears food and gaining weight, which was the case before he began the trek to what he understands to be recovery.

Finally, I ask Eric what he would want to impart to doctors and health care professionals who might read this research paper. In addition to finding ways of lessening stigma for males around both identification around and treatment for anorexia, he articulates a desire for more candid conversations around social oppression and inequity.

YASEEN: I guess my final question would be… what do you think would have been helpful in your recovery? Because you talked a little bit about how the nutritionist was not helpful. Or maybe this was helpful in terms of meditation, but
if I were to kind of presenting this information to clinicians, people in the medical community, what would help -- what would have helped your treatment?

ERIC: Uh. I think explicitly calling out how messed up our culture is. Because I think until I was given the vocabulary to fight back against it, I was a lot less successful. And then when I was able to put a name to what I was thinking or minor twinges of discomfort I might have thought… that helped a lot. Um.

YASEEN: Where did this vocabulary come from?

ERIC: My feminist friends, they helped a lot. And my queer friends. But they're very, like, progressive, anti-oppressive type people, so I mean they're not representative of most any other people I know. They just use those words a lot for things that they saw or experienced…

But things that would have helped… Intuitive eating right away would have helped. The clinic nutritionist thinking she knew what I needed, intervening that way. Um, monitoring everything, it didn't help me where I was. I mean, ‘cause I did value control. And I didn't have it then. She wasn't letting me have it.

Eric’s empowerment through the language of academic critique is key, especially via falling back on a support system of like-minded friends and allies. But even more illuminating is his feedback about his nutritionist: had she allowed Eric to exercise some decision-making in his eating, would he have pushed back so forcefully against her advice?

In these narratives, there is one persistent theme: that recovery is a contested, non-linear project. It is not a conclusion, nor does it exclude sub-categories of resistance, relapse, disavowal and/or performance. Amidst a medical culture that dismisses the perspectives of anorectics as paranoid and ill-informed, I suggest that we are losing an opportunity to collaborate with people with EDs as they articulate a vision for their health and their own bodies – even if this vision troubles the scales, paradigms, and measurements enforced by the medical and clinical establishments.

Gaining weight is not the clear-cut solution to a problem; rather, allowing each person
the space to name - and then unpack, with their own words - their understanding of hunger or even “recovery” might be a more gainful and productive exercise.
Concluding Thoughts and Reflections

One notion that I have attempted to impart to the reader(s), especially those who are healthcare professionals, is that recovery is not strictly related to higher BMI figures, completing in-patient treatment, and the appearance of healthy, structured eating. My participants all speak plainly of this: that no matter how one defines the intentional act of hunger (a diet? a condition? a politics? lifestyle choice?), and no matter how it appears corporeally, the rest of their lives will be marked by a need to sit with their bodies. Despite the hopes of performing a happy ending, to show the world that they have courageously “fought” and “beaten” anorexia, this is not the full picture. Anorexia is managed, and, sometimes, returned to. At times, the prolonged and excruciating practice of hunger even leads to its logical conclusion: death. This particular aspect is not a celebratory chronicle of anorexia, but one that must be included in the larger picture.

I would hope that this research study serves as a starting point for educators, counselors, therapists, medical professionals, and others who grapple with eating disorders to see the worth in engaging with (as opposed to examining) bodies that are largely rendered invisible in prior research and broader conversations. How much more nuanced and non-intrusive might the interventions of doctors be if they have more insight into the experiences of the individuals that they work with? It is imperative that clinicians and researchers trouble the linearity of an onset-symptoms-recovery discourse development model because it restricts anorexia to a purely somatic phenomenon that can be superficially treated. Further research that is qualitative in nature can assist in advancing the imaginative and semantic parameters around eating disorders. And quantitative studies that rely on questionnaires, surveys, and personality tests require a
more rigorous examination before utilization, particularly those that presume causality and then reify those contributing factors as absolutes later on. These measures too have their own versions of onset, duration/practices, and recovery that may or may not do justice to those undergoing anorexic experiences.

As well, prior literature on anorexia nervosa and males requires critique, revisiting, and supplementation, namely via case studies, narrative interviews, and grounded theory approaches to data collection. Such an endeavor would be tremendous, especially in terms of creating new associations, but this is precisely what could provide a worthwhile counterpart to clinical figures on the same phenomena. In focusing on the thoughts and observations of anorectics, we can attempt to lessen the shame that males may feel while seeking treatment or “coming out” as eating-disordered. We may even develop recovery and treatment programs that negotiate boundaries of control that allow these patients to exercise agency and make decisions about their bodies. By the same token, I orient this work largely towards those who do not have EDs, but may work with or know someone who does. I am sure that having a wealth of balanced, detailed research - both medical and otherwise - would have helped my doctors and family members have an insight into my vantage point during the more advanced stages of my hunger practices.

Richardson and Cherry, in their work on online pro-anorexia subcultures, suggest that anorexics in this liberating context are able to reposition “themselves as the experts on anorexia through their experiences” (123). By rejecting the words of doctors and textbooks, they are able to re-appropriate the language to describe their lifestyle choices, even if this outlook carried dangerous implications for their bodies. Although a pro-ana political position does not necessarily fit the attitudes of the male anorectics here, perhaps
this project has granted them a similar forum to reclaim their bodies from an objective third person observer of scientific inquiry. It is my optimistic expectation that ongoing research will open the door for many such opportunities and avenues for self-articulation by narrators of this research and inquiry. Non-normative eating practices necessitate acknowledgment and study as relational phenomena of meaning-making, ones that the anorectics themselves indisputably formulate. The programmatic and interventionist response to anorexia, it is clear, is itself restrictive, in both speaking to these individuals’ behaviours or even as a nuanced medicalized realm of knowledge. The imagination of how to speak to and treat anorexia is so limited in this particular regard, as we see from how the participants in this study have given voice to their self-actualization and nourishment through and within such hunger practices.
WORKS CITED


Siever, Michael. “Sexual Orientation and Gender as Factors in Socioculturally Acquired


Appendix A


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**Anorexia Nervosa**

**Diagnostic Criteria**

A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. *Significantly low weight* is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding note: The ICD-9-CM code for anorexia nervosa is 307.1, which is assigned regardless of the subtype. The ICD-10-CM code depends on the subtype (see below).

Specify whether:

(F50.01) Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

(F50.02) Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behavior that interferes with weight gain) or Criterion C (disturbances in self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI ≥ 17 kg/m²
Moderate: BMI 16–16.99 kg/m²
Severe: BMI 15–15.99 kg/m²
Extreme: BMI < 15 kg/m²

Subtypes

Most individuals with the binge-eating/purging type of anorexia nervosa who binge eat also purge through self-induced vomiting or the misuse of laxatives, diuretics, or enemas. Some individuals with this subtype of anorexia nervosa do not binge eat but do regularly purge after the consumption of small amounts of food.

Crossover between the subtypes over the course of the disorder is not uncommon; therefore, subtype description should be used to describe current symptoms rather than longitudinal course.

Diagnostic Features

There are three essential features of anorexia nervosa: persistent energy intake restriction; intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain; and a disturbance in self-perceived weight or shape. The individual maintains a body weight that is below a minimally normal level for age, sex, developmental trajectory, and physical health (Criterion A). Individuals' body weights frequently meet this criterion following a significant weight loss, but among children and adolescents, there may alternatively be failure to make expected weight gain or to maintain a normal developmental trajectory (i.e., while growing in height) instead of weight loss.
Criterion A requires that the individual's weight be significantly low (i.e., less than minimally normal or, for children and adolescents, less than that minimally expected). Weight assessment can be challenging because normal weight range differs among individuals, and different thresholds have been published defining thinness or underweight status. Body mass index (BMI, calculated as weight in kilograms/height in meters$^2$) is a useful measure to assess body weight for height. For adults, a BMI of 18.5 kg/m$^2$ has been employed by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) as the lower limit of normal body weight. Therefore, most adults with a BMI greater than or equal to 18.5 kg/m$^2$ would not be considered to have a significantly low body weight. On the other hand, a BMI of lower than 17.0 kg/m$^2$ has been considered by the WHO to indicate moderate or severe thinness; therefore, an individual with a BMI less than 17.0 kg/m$^2$ would likely be considered to have a significantly low weight. An adult with a BMI between 17.0 and 18.5 kg/m$^2$, or even above 18.5 kg/m$^2$, might be considered to have a significantly low weight if clinical history or other physiological information supports this judgment.

For children and adolescents, determining a BMI-for-age percentile is useful (see, e.g., the CDC BMI percentile calculator for children and teenagers). As for adults, it is not possible to provide definitive standards for judging whether a child's or an adolescent's weight is significantly low, and variations in developmental trajectories among youth limit the utility of simple numerical guidelines. The CDC has used a BMI-for-age below the 5th percentile as suggesting underweight; however, children and adolescents with a BMI above this benchmark may be judged to be significantly underweight in light of failure to maintain their expected growth trajectory. In summary, in determining whether Criterion A is met, the clinician should consider available numerical guidelines, as well as the individual's body build, weight history, and any physiological disturbances.

Individuals with this disorder typically display an intense fear of gaining weight or of becoming fat (Criterion B). This intense fear of becoming fat is usually not alleviated by weight loss. In fact, concern about weight gain may increase even as weight falls. Younger individuals with anorexia nervosa, as well as some adults, may not recognize or acknowledge a fear of weight gain. In the absence of another explanation for the significantly low weight, clinician inference drawn from collateral history, observational data, physical and laboratory findings, or longitudinal course either indicating a fear of weight gain or supporting persistent behaviors that prevent it may be used to establish Criterion B.

The experience and significance of body weight and shape are distorted in these individuals (Criterion C). Some individuals feel globally overweight. Others realize that they are thin but are still concerned that certain body parts, particularly the abdomen, buttocks, and thighs, are "too fat." They may employ a variety of techniques to evaluate their body size or weight, including frequent weighing, obsessive measuring of body parts, and persistent use of a mirror to check for perceived areas of "fat." The self-esteem of individuals with anorexia nervosa is highly dependent on their perceptions of body shape and weight. Weight loss is often viewed as an impressive achievement and a sign of extraordinary self-discipline, whereas weight gain is perceived as an unacceptable failure of self-control. Although some individuals with this disorder may acknowledge being thin, they often do not recognize the serious medical implications of their malnourished state.

Often, the individual is brought to professional attention by family members after marked weight loss (or failure to make expected weight gains) has occurred. If individuals seek help on their own, it is usually because of distress over the somatic and psychological sequelae of starvation. It is rare for an individual with anorexia nervosa to complain of weight loss per se. In fact, individuals with anorexia nervosa frequently either lack insight into or deny the problem, it is therefore often important to obtain information from family members or other sources to evaluate the history of weight loss and other features of the illness.
Associated Features Supporting Diagnosis

The semi-starvation of anorexia nervosa, and the purging behaviors sometimes associated with it, can result in significant and potentially life-threatening medical conditions. The nutritional compromise associated with this disorder affects most major organ systems and can produce a variety of disturbances. Physiological disturbances, including anorexia, tachycardia, and vital sign abnormalities, are common. While most of the physiological disturbances associated with malnutrition are reversible with nutritional rehabilitation, some, including loss of bone mineral density, are often not completely reversible. Behaviors such as self-induced vomiting and misuse of laxatives, diuretics, and enemas may cause a number of disturbances that lead to abnormal laboratory findings; however, some individuals with anorexia nervosa exhibit no laboratory abnormalities.

When seriously underweight, many individuals with anorexia nervosa have depressive signs and symptoms such as depressed mood, social withdrawal, irritability, insomnia, and diminished interest in sex. Because these features are also observed in individuals without anorexia nervosa who are significantly undernourished, many of the depressive features may be secondary to the physiological sequelae of semi-starvation, although they may also be sufficiently severe to warrant an additional diagnosis of major depressive disorder.

Obsessive-compulsive features, both related and unrelated to food, are often prominent. Most individuals with anorexia nervosa are preoccupied with thoughts of food. Some collect recipes or hoard food. Observations of behaviors associated with other forms of starvation suggest that obsessions and compulsions related to food may be exacerbated by undernutrition. When individuals with anorexia nervosa exhibit obsessions and compulsions that are not related to food, body shape, or weight, an additional diagnosis of obsessive-compulsive disorder (OCD) may be warranted.

Other features sometimes associated with anorexia nervosa include concerns about eating in public, feelings of ineffectiveness, a strong desire to control one’s environment, inflexible thinking, limited social spontaneity, and overly restrained emotional expression. Compared with individuals with anorexia nervosa, restricting type, those with binge-eating/purging type have higher rates of impulsivity and are more likely to abuse alcohol and other drugs.

A subgroup of individuals with anorexia nervosa show excessive levels of physical activity. Increases in physical activity often precede onset of the disorder, and over the course of the disorder increased activity accelerates weight loss. During treatment, excessive activity may be difficult to control, thereby jeopardizing weight recovery.

Individuals with anorexia nervosa may misuse medications, such as by manipulating dosage, in order to achieve weight loss or avoid weight gain. Individuals with diabetes mellitus may omit or reduce insulin doses in order to minimize carbohydrate metabolism.

Prevalence

The 12-month prevalence of anorexia nervosa among young females is approximately 0.4%. Less is known about prevalence among males, but anorexia nervosa is far less common in males than in females, with clinical populations generally reflecting approximately a 10:1 female-to-male ratio.

Development and Course

Anorexia nervosa commonly begins during adolescence or young adulthood. It rarely begins before puberty or after age 40, but cases of both early and late onset have been described. The onset of this disorder is often associated with a stressful life event, such as leaving home for college. The course and outcome of anorexia nervosa are highly variable. Younger individuals may manifest atypical features, including denying “fear of fat.” Older
individuals more likely have a longer duration of illness, and their clinical presentation may include more signs and symptoms of long-standing disorder. Clinicians should not exclude anorexia nervosa from the differential diagnosis solely on the basis of older age.

Many individuals have a period of changed eating behavior prior to full criteria for the disorder being met. Some individuals with anorexia nervosa recover fully after a single episode, with some exhibiting a fluctuating pattern of weight gain followed by relapse, and others experiencing a chronic course over many years. Hospitalization may be required to restore weight and to address medical complications. Most individuals with anorexia nervosa experience remission within 5 years of presentation. Among individuals admitted to hospitals, overall remission rates may be lower. The crude mortality rate (CMR) for anorexia nervosa is approximately 5% per decade. Death most commonly results from medical complications associated with the disorder itself or from suicide.

Risk and Prognostic Factors

**Temperamental.** Individuals who develop anxiety disorders or display obsessional traits in childhood are at increased risk of developing anorexia nervosa.

**Environmental.** Historical and cross-cultural variability in the prevalence of anorexia nervosa supports its association with cultures and settings in which thinness is valued. Occupations and avocations that encourage thinness, such as modeling and elite athletics, are also associated with increased risk.

**Genetic and physiological.** There is an increased risk of anorexia nervosa and bulimia nervosa among first-degree biological relatives of individuals with the disorder. An increased risk of bipolar and depressive disorders has also been found among first-degree relatives of individuals with anorexia nervosa, particularly relatives of individuals with the binge-eating/purging type. Concordance rates for anorexia nervosa in monozygotic twins are significantly higher than those for dizygotic twins. A range of brain abnormalities has been described in anorexia nervosa using functional imaging technologies (functional magnetic resonance imaging, positron emission tomography). The degree to which these findings reflect changes associated with malnutrition versus primary abnormalities associated with the disorder is unclear.

**Culture-Related Diagnostic Issues**

Anorexia nervosa occurs across culturally and socially diverse populations, although available evidence suggests cross-cultural variation in its occurrence and presentation. Anorexia nervosa is probably most prevalent in post-industrialized, high-income countries such as in the United States, many European countries, Australia, New Zealand, and Japan, but its incidence in most low- and middle-income countries is uncertain. Whereas the prevalence of anorexia nervosa appears comparatively low among Latinos, African Americans, and Asians in the United States, clinicians should be aware that mental health service utilization among individuals with an eating disorder is significantly lower in these ethnic groups and that the low rates may reflect an ascertainment bias. The presentation of weight concerns among individuals with eating and feeding disorders varies substantially across cultural contexts. The absence of an expressed intense fear of weight gain, sometimes referred to as “fat phobia,” appears to be relatively more common in populations in Asia, where the rationale for dietary restriction is commonly related to a more culturally sanctioned complaint such as gastrointestinal discomfort. Within the United States, presentations without a stated intense fear of weight gain may be comparatively more common among Latino groups.

**Diagnostic Markers**

The following laboratory abnormalities may be observed in anorexia nervosa; their presence may serve to increase diagnostic confidence.
Hematology. Leukopenia is common, with the loss of all cell types but usually with apparent lymphocytosis. Mild anemia can occur, as well as thrombocytopenia and, rarely, bleeding problems.

Serum chemistry. Dehydration may be reflected by an elevated blood urea nitrogen level. Hypercholesterolemia is common. Hepatic enzyme levels may be elevated. Hypercalcemia, hypoglycemia, hypophosphatemia, and hyperamylasemia are occasionally observed. Self-induced vomiting may lead to metabolic alkalosis (elevated serum bicarbonate), hyperchloremia, and hypokalemia; laxative abuse may cause a mild metabolic acidosis.

Endocrine. Serum thyroxine (T₄) levels are usually in the low-normal range; triiodothyronine (T₃) levels are decreased, while reverse T₃ levels are elevated. Females have low serum estrogen levels, whereas males have low levels of serum testosterone.

Electrocardiography. Sinus bradycardia is common, and, rarely, arrhythmias are noted. Significant prolongation of the QTc interval is observed in some individuals.

Bone mass. Low bone mineral density, with specific areas of osteopenia or osteoporosis, is often seen. The risk of fracture is significantly elevated.

Electroencephalography. Diffuse abnormalities, reflecting a metabolic encephalopathy, may result from significant fluid and electrolyte disturbances.

Resting energy expenditure. There is often a significant reduction in resting energy expenditure.

Physical signs and symptoms. Many of the physical signs and symptoms of anorexia nervosa are attributable to starvation. Amenorrhea is commonly present and appears to be an indicator of physiological dysfunction. If present, amenorrhea is usually a consequence of the weight loss, but in a minority of individuals it may actually precede the weight loss. In prepubertal females, menarche may be delayed. In addition to amenorrhea, there may be complaints of constipation, abdominal pain, cold intolerance, lethargy, and excess energy.

The most remarkable finding on physical examination is emaciation. Commonly, there is also significant hypotension, hypothermia, and bradycardia. Some individuals develop lanugo, a fine downy body hair. Some develop peripheral edema, especially during weight restoration or upon cessation of laxative and diuretic abuse. Rarely, petechiae or ecchymoses, usually on the extremities, may indicate a bleeding diathesis. Some individuals evidence a yellowing of the skin associated with hypercarotenemia. As may be seen in individuals with bulimia nervosa, individuals with anorexia nervosa who self-induce vomiting may have hypertrophy of the salivary glands, particularly the parotid glands, as well as dental enamel erosion. Some individuals may have scars or cellulites on the dorsal surface of the hand from repeated contact with the teeth while inducing vomiting.

Suicide Risk

Suicide risk is elevated in anorexia nervosa, with rates reported as 12 per 100,000 per year. Comprehensive evaluation of individuals with anorexia nervosa should include assessment of suicide-related ideation and behaviors as well as other risk factors for suicide, including a history of suicide attempt(s).

Functional Consequences of Anorexia Nervosa

Individuals with anorexia nervosa may exhibit a range of functional limitations associated with the disorder. While some individuals remain active in social and professional functioning, others demonstrate significant social isolation and/or failure to fulfill academic or career potential.
Differential Diagnosis

Other possible causes of either significantly low body weight or significant weight loss should be considered in the differential diagnosis of anorexia nervosa, especially when the presenting features are atypical (e.g., onset after age 40 years).

Medical conditions (e.g., gastrointestinal disease, hyperthyroidism, occult malignancies, and acquired immunodeficiency syndrome (AIDS)). Serious weight loss may occur in medical conditions, but individuals with these disorders usually do not also manifest a disturbance in the way their body weight or shape is experienced or an intense fear of weight gain or persist in behaviors that interfere with appropriate weight gain. Acute weight loss associated with a medical condition can occasionally be followed by the onset or recurrence of anorexia nervosa, which can initially be masked by the comorbid medical condition. Rarely, anorexia nervosa develops after bariatric surgery for obesity.

Major depressive disorder. In major depressive disorder, severe weight loss may occur, but most individuals with major depressive disorder do not have either a desire for excessive weight loss or an intense fear of gaining weight.

Schizophrenia. Individuals with schizophrenia may exhibit odd eating behavior and occasionally experience significant weight loss, but they rarely show the fear of gaining weight and the body image disturbance required for a diagnosis of anorexia nervosa.

Substance use disorders. Individuals with substance use disorders may experience low weight due to poor nutritional intake but generally do not fear gaining weight and do not manifest body image disturbance. Individuals who abuse substances that reduce appetite (e.g., cocaine, stimulants) and who also endorse fear of weight gain should be carefully evaluated for the possibility of comorbid anorexia nervosa, given that the substance use may represent a persistent behavior that interferes with weight gain (Criterion B).

Social anxiety disorder (social phobia), obsessive-compulsive disorder, and body dysmorphic disorder. Some of the features of anorexia nervosa overlap with the criteria for social phobia, OCD, and body dysmorphic disorder. Specifically, individuals may feel humiliated or embarrassed to be seen eating in public, as in social phobia; may exhibit obsessions and compulsions related to food, as in OCD; or may be preoccupied with an imagined defect in bodily appearance, as in body dysmorphic disorder. If the individual with anorexia nervosa has social fears that are limited to eating behavior alone, the diagnosis of social phobia should not be made, but social fears unrelated to eating behavior (e.g., excessive fear of speaking in public) may warrant an additional diagnosis of social phobia. Similarly, an additional diagnosis of OCD should be considered only if the individual exhibits obsessions and compulsions unrelated to food (e.g., an excessive fear of contamination), and an additional diagnosis of body dysmorphic disorder should be considered only if the disturbance is unrelated to body shape and size (e.g., preoccupation that one’s nose is too big).

Bulimia nervosa. Individuals with bulimia nervosa exhibit recurrent episodes of binge eating, engage in inappropriate behavior to avoid weight gain (e.g., self-induced vomiting), and are overly concerned with body shape and weight. However, unlike individuals with anorexia nervosa, binge-eating/purging type, individuals with bulimia nervosa maintain body weight at or above a minimally normal level.

Avoidant/restrictive food intake disorder. Individuals with this disorder may exhibit significant weight loss or significant nutritional deficiency, but they do not have a fear of gaining weight or of becoming fat, nor do they have a disturbance in the way they experience their body shape and weight.

Comorbidity

Bipolar, depressive, and anxiety disorders commonly co-occur with anorexia nervosa. Many individuals with anorexia nervosa report the presence of either an anxiety disorder.
or symptoms prior to onset of their eating disorder. OCD is described in some individuals with anorexia nervosa, especially those with the restricting type. Alcohol use disorder and other substance use disorders may also be comorbid with anorexia nervosa, especially among those with the binge-eating/purging type.
Appendix A.2


**Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)**

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<td></td>
<td>feeding:</td>
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<td></td>
<td>- difficulties and mismanagement (R63.3)</td>
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<td></td>
<td>- disorder of infancy or childhood (F98.2)</td>
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<table>
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<tr>
<th>F50.0</th>
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<td></td>
<td>A disorder characterized by deliberate weight loss, induced and sustained by the patient. It occurs most commonly in adolescent girls and young women, but adolescent boys and young men may also be affected, as may children approaching puberty and older women up to the menopause. The disorder is associated with a specific psychopathology whereby a dread of fatness and flabbiness of body contour persists as an intrusive overvalued idea, and the patients impose a low weight threshold on themselves. There is usually undernutrition of varying severity with secondary endocrine and metabolic changes and disturbances of bodily function. The symptoms include restricted dietary choice, excessive exercise, induced vomiting and purging, and use of appetite suppressants and diuretics.</td>
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Appendix B

Men, Body Image, and Eating Disorders

Ann Kearney-Cooke
and Paule Steichen-Asch

That the earliest human experience is somatic is a widely held view in the literature on body image, psychosexual, and psychosocial development (Chodorow, 1978; Erikson, 1950; Freud, 1933; Greenacre, 1958; Restenber, 1975; Piaget, 1954; Schilder, 1950). These theorists generally agree that body image, a cognitive construct, forms as the infant becomes capable of distinguishing and integrating sensations. The body image is particularly complex because it appears to include surface, depth, and postural pictures of the body as well as the attitudes, emotions, and personality reactions of individuals to their bodies (Kolb, 1959). In addition, it incorporates cultural attitudes.

Body image is crucial to the early personality formation in the child, especially to the differentiation of the self from the world, as the sense of body boundaries is formed. Because the body is the only object in a person’s perceptual field which simultaneously is perceived and is part of oneself, theorists have proposed an equation between body feelings and personality patterns (Fisher, 1966; Schilder, 1935). The unique closeness of the individual’s body to his identity maximizes the likelihood that it reflects and shares his most important preoccupations. Fisher (1966) states that the body, like all significant objects, can become a convenient “screen” on which one projects one’s most intense concerns.

Disturbance of body image is a multidimensional phenomenon, including such issues as distortion of body size, dissatisfaction with body size, concern with body shape, and insensitivity to introceptive cues (Cooper & Taylor, in press; Garner & Garfinkel, 1981). The purpose of this chapter is to identify the body image concerns of men and to discuss the ways in which personality development and body image development may interact to leave a male at risk for concerns about body shape and for an eating disorder. We will also suggest treatments which might address these issues. In particular, we will address the following questions: Do male eating-disordered patients suffer body image disturbance? If they do so, what is the nature of the disturbance? How do normal, non-eating-disordered college men feel about their bodies? What factors in demography, body image history, and personality structure might predispose a man to develop an eating disorder? What factors in development seem to leave some men vulnerable about their bodies? Why do many men aspire to a full-chested, lean-waisted look while others attempt to make their bodies thin?

The answers to these questions will come in part from a study of 16 men with eating disorders and 112 male college students. The remainder of this chapter consists of a description of the research study, discussion of research findings, and recommendations for treatment. We end with a summary and some suggestions for future research.

DESCRIPTION OF RESEARCH STUDY

Subjects

The noneating-disordered group comprised 112 male college students from introductory psychology courses in a university in the Midwest. The average age of the subjects was 20.3 years (range 17 to 37). Participants were predominantly single (97%) and white (89%). Forty-four percent were raised Catholic, 30% Protestant, and 2% Jewish; 10% had no religious training. Participation was voluntary, although subjects received class credit.

The 112 college men were divided into two groups: the “at-risk” group (n = 28), those men with scores on the Body Shape Questionnaire that were within the range of the eating-disordered patients’ scores, and the “normal”
Males with Eating Disorders

base rate (BR) scores, which are transformed scores designed to maximize correct diagnostic classification by optimizing valid-positive to false-positive ratios. A BR score of 75 indicates that a particular trait is likely to be present, while a BR score of 35 represents the median score of a normal or nonclinical group (Millon, 1982).

The demographic questionnaire was designed by the first author to examine body image history. It included questions about memories of parents’ attitudes towards their own and the subject’s body, peers’ reactions to bodies, importance of relationships, preferred body shape for men and for women, and earliest memory of feeling shame about the body. The open-ended answers were classified in categories and coded.

Procedure

The noneating-disordered group of subjects was recruited through the subject pool of the University of Cincinnati’s Psychology Department. During the first week of classes, we made a standard announcement soliciting participation in an experiment on body image for males. After students signed up, they met with the research assistant in a large group testing session. They were asked to fill out a demographic questionnaire and instruments asking questions about body image, eating disorders, and personality patterns. After completing the tests in the research packet, the students were told that they could receive the results of the study if they wished.

For the clinical population, patients were recruited through individual therapists, support groups, and hospital units specializing in the treatment of eating disorders. After the clinician determined that a male patient met the diagnostic criteria for an eating disorder, the therapist gave the patient the research packet to fill out. The completed packet then was forwarded to the first author to be coded for research.

RESULTS

Concerns of Contemporary Men: Summary of Responses to Open-Ended Questions

With regard to body parts of which one is ashamed, the response given by most men in all three groups was “stomach, gut, belly,” followed by “upper and lower extremities.”

In regard to the ideal male body shape for contemporary men, the normal
group (Group 1) and the at-risk group (Group 2) most often gave the response “muscular, strong, and broad shoulders.” By contrast, the men with eating disorders (Group 3) most often described the “lean, toned, thin” shape as their ideal.

In regard to the ideal female body shape, the response given most often by all three groups was “thin, slim, slightly underweight.” In the normal and the at-risk group, the next most frequent response was “shapely, well-proportioned.” For men with eating disorders, however, the second most popular response was “big breasts, voluptuous, or firm and solid.”

Analysis of Variances

A group of analyses of variance was computed comparing normal, at-risk, and eating-disordered men on the following variables. Table 1 summarizes the results.

On parental variables, the groups showed no differences with regard to father's positive attitude toward his own body. For two other variables, however—amount of contact with father and closeness to parents—we noted significant differences among the three groups; the means were most normal for Group 1 and least normal for Group 3.

On variables related to peers' reactions to their bodies, we found significant differences among the three groups in the directions expected. Men struggling with eating disorders (Group 3) reported that they were teased more about their bodies while growing up and were preferred less for athletic teams. Their sexual preferences included homosexuality and bisexuality, whereas all the subjects in Groups 1 and 2 reported being heterosexual.

On the variable related to body satisfaction, there was a significant difference among the three groups in the expected direction. Results were also as expected for the summary score on the Eating Attitudes Test: men in Group 3 scored the highest.

Table 2 presents the results of the personality variables data. It displays the mean base rate (BR) scores for the MCMR, as the three groups. Base rate scores are obtained by transforming raw scores to reflect known personality and syndrome prevalence rates (Millon, 1982). For general interpretive purposes, a BR score of 75 or more identifies the presence of a trait or disorder. F-ratios are displayed in Table 2.

For the basic personality pattern scales, with the exception of compulsive, all results were highly significant in the expected direction. Group 1 (normal) scored highest on histrionic/gregarious, narcissistic, and antisocial/aggressive. Group 3 (eating-disordered men) scored highest on avoidant, dependent, and passive-aggressive.
### Table 2

Analysis of Variance for Three Groups: Basic Personality Pattern and Pathological Personality Disorder

<table>
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<th>Item</th>
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<th>At Risk (N = 27)</th>
<th>Balantics (N = 16)</th>
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<td>Mean Std.Dev.</td>
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<tr>
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<td>22.31</td>
<td>42.38</td>
<td>28.29</td>
<td>59.53</td>
</tr>
<tr>
<td>Avoidant</td>
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<td>24.01</td>
<td>48.50</td>
<td>28.09</td>
<td>71.47</td>
</tr>
<tr>
<td>Dependent</td>
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<td>26.10</td>
<td>61.38</td>
<td>31.67</td>
<td>73.13</td>
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<td>69.85</td>
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<td>Narcissistic</td>
<td>72.59</td>
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<td>66.50</td>
<td>22.83</td>
<td>50.93</td>
</tr>
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<td>Antisocial</td>
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<td>63.88</td>
<td>24.78</td>
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<td>14.28</td>
<td>54.54</td>
<td>17.67</td>
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</tr>
<tr>
<td>Passive Aggressive</td>
<td>45.45</td>
<td>23.24</td>
<td>57.04</td>
<td>24.28</td>
<td>67.63</td>
</tr>
<tr>
<td><strong>Pathological Personality Disorder</strong></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Schizotypal</td>
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<td>19.92</td>
<td>60.07</td>
</tr>
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<td>16.90</td>
<td>53.69</td>
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</tr>
<tr>
<td>Paranoid</td>
<td>62.69</td>
<td>14.21</td>
<td>63.92</td>
<td>17.29</td>
<td>54.47</td>
</tr>
</tbody>
</table>

Note: High score means high syndrome. A score of 75 or more is interpreted as pathological.

---

**Discriminant Analysis Among Normal, At-Risk, and Balantic Men**

We used a multiple discriminant function to determine whether selected variables were effective in discriminating among the normal, at-risk, and balantic men. For obvious reasons, the Eating Attitudes Test and body dissatisfaction were not considered as predictors, because a balanced multiple discriminant analysis was used. The variables were selected, as in the preceding analysis of variance, because (1) variables were selected so that the preceding dimensions measured earlier family function, and personality; and (2) variables were selected to assess the extent of dimensional overlap among the three groups (see Table 3). Seven variables were selected for the discriminant function analysis.

### Table 3

#### Discriminant Analysis Using Seven Measures as Discriminant Variables among Normal, At-Risk, and Balantic Men

<table>
<thead>
<tr>
<th>Measure</th>
<th>Group</th>
<th>Canonical Discriminant Functions</th>
<th>Classification Table</th>
<th>Function 1</th>
<th>Function 2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Normal</td>
<td></td>
<td>at Risk</td>
<td>at Risk</td>
<td>Balantic</td>
</tr>
<tr>
<td></td>
<td>83.8%</td>
<td>50.0%</td>
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<td>50.0%</td>
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<td>26.7%</td>
<td>20.7%</td>
<td>26.7%</td>
<td>20.7%</td>
</tr>
<tr>
<td>At Risk</td>
<td>15.0%</td>
<td>26.7%</td>
<td>20.7%</td>
<td>26.7%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Balantic</td>
<td>25.1%</td>
<td>19.7%</td>
<td>26.7%</td>
<td>19.7%</td>
<td>19.7%</td>
</tr>
</tbody>
</table>

Discriminant Analysis Using Seven Measures as Discriminant Variables among Normal, At-Risk, and Balantic Men

We used a multiple discriminant function to determine whether selected variables were effective in discriminating among the normal, at-risk, and balantic men. For obvious reasons, the Eating Attitudes Test and body dissatisfaction were not considered as predictors, because a balanced multiple discriminant analysis was used. The variables were selected, as in the preceding analysis of variance, because (1) variables were selected so that the preceding dimensions measured earlier family function, and personality; and (2) variables were selected to assess the extent of dimensional overlap among the three groups (see Table 3). Seven variables were selected for the discriminant function analysis.
entered. The maximum of two discriminant functions was calculated; the resulting combined $X^2$ [(14, N=124) = 50.63, $p < .0001$] was significant. The canonical correlation between the first discriminant function and group membership was .56 (between-group variability accounted for 91% of the variance).

After removal of this first discriminant function among the three groups, there was no significant discriminating power associated with the second function ($X^2$ (6, N=124) = 5.27). An examination of the group centroids of the first discriminant function among the three groups discriminated between at-risk ($C = .43$) and eating-disordered ($C = 1.57$) men, but also between at-risk and normal ($C = - .42$) men.

On the basis of this discriminant analysis, 63% of the cases (124 cases) would have been classified correctly into the appropriate group. More specifically, 66.3% of the normal men, 46.2% of the at-risk men, and 73.3% of the eating-disordered men would have been classified correctly into the appropriate group on the basis of the first discriminant function (the second did not explain much additional variability among groups). Thus, sensitivity (ability to detect eating-disordered men) was slightly better than specificity (accuracy in identifying normal cases). Variables correlated most highly with the first discriminant function were avoidant personality, rejection from athletic teams, absence of a narcissistic pattern, and dependent personality (see Table 4). The remaining variables (lack of closeness to parents, a passive-aggressive character, and a history of having been teased) also correlated with the function.

### Table 4

<table>
<thead>
<tr>
<th>Variables</th>
<th>Correlation with Discriminant Function</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Function 1</td>
</tr>
<tr>
<td>Avoidant personality</td>
<td>.71</td>
</tr>
<tr>
<td>Rejection in athletic teams</td>
<td>.57</td>
</tr>
<tr>
<td>Narcissistic personality</td>
<td>- .54</td>
</tr>
<tr>
<td>Dependent personality</td>
<td>.51</td>
</tr>
<tr>
<td>Lack of closeness to parents</td>
<td>.50</td>
</tr>
<tr>
<td>Passive-aggressive peers</td>
<td>.49</td>
</tr>
<tr>
<td>History of being teased</td>
<td>- .37</td>
</tr>
</tbody>
</table>

**DISCUSSION**

**Body Image Concerns of College Men**

This study found that the preferred body shape for contemporary men without eating disorders was the V-shaped body, whereas the eating-disordered group strove for the "lean, toned, thin" shape.

It is puzzling that most men still prefer the full-chested, thin-waisted body shape, as well as the look of strength and agility. Lipman (1962) states that the early American value system, which stressed the attributes of physical prowess for men, made sense then because it was anchored in and related functionally to the frontier and rural society. He suggests that the perpetuation of this old rural ideal of manliness represents one of the most serious cultural lags of our time; certainly, male physical strength and prowess are not prerequisites for success in most careers, as they were in the past. This particular shape seems to gain importance during adolescence.

For the adolescent, the changes in physique, a developing ability to think abstractly, and the subsequent capacity for self-reflection mark the beginning of a period of extreme physical and psychological self-consciousness. At the same time as the adolescent male is attempting to integrate the somatic changes of puberty, he is trying to understand the meaning of becoming a man in our culture. From birth, most boys learn that being a man entails a certain set of attitudes and behaviors, including independence, competitiveness, toughness, aggressiveness, and courage. This set of values may explain in part why noneating-disordered men scored highest on the antisocial, narcissistic, and histrionic scales of the Millon inventory. Although some of these traits certainly are desirable, others can be problematic, lead to emotional isolation, and limit the development of a boy's potential.

Through their peers and through the media, young men are confronted daily with a definition of manhood which is distorted, dysfunctional, and potentially destructive. The popular ideal overemphasizes physical strength, force, and athletic skills. Yet where else can adolescent boys turn to understand their emerging manhood?

Fogel (1986) proposes that masculinity often is defined in relation and in contrast to women. During the last 20 years, however, popular conceptions of women's role in society have begun to change dramatically in American culture. One important component of this change is women's increased participation in economic and professional life, particularly in occupations and at levels reserved previously for men. Consequently, a man's career, which formerly played a major role in his identity, now is often a source of anxiety
and tension. In addition, turning to women to gain a better understanding of masculinity is more difficult today because women are reassessing their own roles and because their own identity is in flux.

Researchers have found that increased achievement and competence among women due to the designation of occupations by gender presents problems for men (Bowman, Worthy, & Greyser, 1965). Fleck (1973) points out that traditional norms for male-female relations and sex-role socialization have not prepared men to interact with achieving women either as partners in marriage or as peers at work. Could women’s entry into economic and professional life be generating a “male backlash”? Is this backlash being expressed in part through an idealization of the powerful V-shaped body and the recent trends in men’s fashions? In the February 1, 1988, edition of Newsweek, one of the top stories was titled “Sylvan Chic: The Marketing of Masculinity.” The editor introduces the story by reporting that the “pseudo-sportsman” look has become “a big hit in the upscale urban jungle,” where “men who never leave the sidewalk are buying (among other items) expensive rubber-soled shoes. The editor proposes that “designers are cashing in on the nostalgia for a time when men were men.”

With both males and females reassessing their sex roles, it is not surprising that adolescence, a time of transition, is the period when many persons of both genders develop eating disorders and obsessions with their bodies. Because we are focusing on males, we are left with questions about the meaning of the ideal male shape. Do the presentation of a powerful body type and the trend toward rugged fashion make a statement about men’s longing for a time when men were in charge? Do the men who feel threatened by the women’s movement need to “flex their muscles” in an attempt to be sexually dominant as their traditional masculine prerogatives ebb away?

**Men with Eating Disorders**

Although there are many paths to the development of an eating disorder, a preliminary risk factor model emerged through the discriminant function analysis. Men with eating disorders tend to have dependent, avoidant, and passive-aggressive personality styles, and to have experienced negative reactions to their bodies from their peers while growing up. They tend to be closer to their mothers than to their fathers. The discussion that follows will describe the overall group profile that emerged and the ways in which personality and body image development may interact to place a man at risk for concerns about body shape and for an eating disorder.

**Men, Body Image, and Eating Disorders**

With regard to the personality profile, men with eating disorders score highest on the dependent, avoidant, and passive-aggressive scales on the MCMI. These patterns, according to Millon (1982), reflect relatively enduring and pervasive traits that typify a person’s style of behaving, perceiving, thinking, feeling, and relating to others. Millon (1981) describes these personality styles in the following ways.

Dependent personalities are distinguished from other pathological patterns by their marked need for social approval and affection and by their willingness to live in accord with the desires of others. They adapt their behavior to please those on whom they depend; their search for love leads them to deny thoughts and feelings that may arouse the displeasure of others. Such individuals avoid asserting themselves lest their actions be seen as aggressive. Dependents may feel paralyzed when alone, and need repeated assurance that they will not be abandoned. Unable to draw on themselves as a major source of comfort and gratification, they must arrange their lives to ensure a constant supply of nurturance and reinforcement from their environment. To protect themselves from losing the affection and protection of those on whom they depend, dependents submit quickly and comply with others’ wishes, or make themselves so pleasing that no one could possibly want to abandon them.

Millon (1981) describes the avoidant personality as an “actively” detached person who is oversensitive to social stimuli and hyperreactive to the moods and feelings of others, especially those moods and feelings that portend rejection and humiliation. Their extreme anxiety not only intrudes into their thoughts and interferes with their behavior but also disposes them to distance themselves from others as a protection against the psychic pain they anticipate.

A distinguishing feature of the passive-aggressive personality is the belief that those who suffer from it were subjected to appreciably more than their share of contradictory family messages. Their eroticism and capriciousness, their tendency to shift from agreeableness to negativity, simply mirror the inconsistent models and reinforcement to which they were exposed. They have deeply rooted feelings of ambivalence about themselves and others. The name of this disorder is based on the assumption that such individuals are expressing covert aggression passively.

What factors in development might explain why eating-disordered men develop such a passive-dependent approach to life and why controlling their body becomes their avenue to gain control? In what ways do body image and psychosocial development interact to leave a man vulnerable to concerns about his body?
Speculations About the Interaction Between Personality and Body Image Development

Our findings followed logically from the work of previous researchers. Fisher, Fisher, and Stark (1980), for example, proposed that body image development begins before birth. It involves the parents' preconceived image of how they would like the baby to be and what they want the baby to look like. This image is an ideal one, which is influenced by the parents' own body image history (Kearney-Cooke, in press). Fisher et al. (1980) state that when the baby is born, the parents will welcome it into the world if enough similarities exist between their ideal image and the baby's actual appearance. The baby's emotional needs then can be met by a loving environment, which leads to feelings of personal worth; these feelings, in turn, are the basis of a secure body image.

According to Mahler, Pine, and Bergman (1975), the child has increased internal perception at the age of four or five months, and begins to differentiate his own body from his mother's. He distinguishes his body from other objects in the environment through kinesesthetic, visceral, and motor sensations. Adequate somatic sensory stimulation, such as touching, rocking, and water play, are important for the development of body image in the infant. Blasing and Brockhaus (1972) state that if the infant does not receive adequate tactile and vestibular stimulation his ego development will be impaired, his level of anxiety will increase, and he will have a poor foundation for reality testing. By the end of the first year, the child develops the ability to move away physically from his mother; eventually he can walk and distinguish his body from the rest of the world.

Mahler et al. (1975) describe the period from approximately 18 to 22 months as a time when the child wants to explore the world and move away from his mother, but is in conflict. He fears engulfment on the one hand and loss of the love of the other. Boys become aware during this stage that girls do not have a penis; consequently they develop a more distinct awareness of their own bodies and their relation to other people's bodies.

Erikson (1950) describes the toddler stage as lasting from one to three years of age. Mastery of body and environment are major tasks of this stage; toddlers struggle to acquire motor skills, language skills, and bowel training. The parents' approval or disapproval of the toddler's more autonomous behavior and appearance has a significant effect on the child's developing sense of self and body image. Depending on the parents' reactions, the children may regard the body and its parts as good or bad, pleasing or repulsive, clean or dirty, loved or disliked. If a child's strivings toward independence, often expressed somatically, are accepted by his family during this period, he will accept himself and his body and will not overvalue or devalue his body. If he feels that there is something wrong with his interest in venturing out on his own, however, he will develop feelings of shame, helplessness, and inadequacy.

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

Sex typing and sex-role identification also are major tasks of the toddler stage. In our culture, muscular build, overt physical aggression, competence at athletics, competitiveness, and independence generally are regarded as desirable for boys, whereas dependency, passivity, inhibition of physical aggression, smallness, and neatness are seen as more appropriate for females. Boys who later develop eating disorders do not conform to the cultural expectations for masculinity; they tend to be more dependent, passive, and nonathletic traits which may lead to feelings of isolation and disparagement of body.

Schilder (1950) proposed that an individual develops conscious and unconscious attitudes about his or her body through identification with another person. In regard to closeness with each parent, the findings of our study support what Sours (1950) and Dally (1969) found in their research: men with eating disorders report feeling close to their mother and having little contact with their fathers. Sours (1950) hypothesized that this increased identification with mother might play a role in the eating-disordered man's need to rid the body of all fat. This notion fits what one bulimic man wrote in response to the question on the demographic questionnaire about the time when he felt most ashamed of his body: "I was doing wash with a friend. He pulled a pair of pants out of the machine and didn't know who they belonged to. They were so big, my friend said they must belong to my mother—they were mine."

As a child leaves home and enters school, the reaction of peers also plays
a role in body image development. For the first time the child enters a group
that has no special interest in him. The members of the group are at an age
where they must compete and assert their own ability to survive outside their
homes. Often, popularity and leadership are based largely on appearance
(Fisher et al., 1980). We found that most of the men with eating disorders
reported negative reactions from their peers. They reported being the last
ones chosen for athletic teams and often cited being teased by peers about
their bodies as the times when they felt most ashamed of their bodies.
Unfortunately, the sense of ineffectiveness and inferiority about their
appearance and body competencies was confirmed as they ventured out of
the home. Feelings of unattractiveness and inadequacy may have resulted
in more social humiliation and self-doubt. The result may have been to retreat
further into the home and to attempt to change their bodies to gain a sense
of power and control.

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

RECOMMENDATIONS FOR TREATMENT

On the basis of the results of this study, the authors find Hilde Bruch’s (1973,
1978) conceptualization of eating disorders most helpful in planning the
overall treatment.

Therapy must assist the eating-disordered male in developing a more
cohesive sense of self, a true self in which all aspects of his personality can be
expressed, not only those which he feels found acceptable. Separation issues
also must be addressed, including the separateness of his own body image
from the bodies of significant others, which would help these patients to have
a less distorted view of fat. The patient also must work through the issue of
control through self-knowledge and expression versus the pseudocontrol
experienced through weight loss. In addition, therapy must address his
vulnerability around body image and its relationship to the development and
maintenance of an eating disorder.

Because these men struggle for acceptance by others even at the cost of
silencing themselves, the authors suggest that the body image work take place
in a group. This format would provide them with a place to experiment with
more direct, more honest communication while exploring the history of their
body image development and the meaning of male body types.

Guided imagery can be used in the treatment of body image disturbance.
Before presenting the two theme-centered guided imageries, we would like to
describe this technique briefly.

During the past two decades, there has been a proliferation of research and
reports about the clinical application of guided imagery in treating an extensive
range of disorders, including body image (Hutchinson, 1983; Kearney-Cooke,
in press; Schulz, 1978; Wooley & Kearney-Cooke, 1986). It has been found that
guided imagery is a powerful tool when used in treatment approaches ranging
from psychoanalytic psychotherapy (Reiker, 1977) to behavioral (Wolpe,
1958).

Guided imagery is a fantasy-inducing process which combines deep muscle
relaxation and the suggestion of images. It is a powerful technique for psychic
reconstruction whereby repressed material around the body can be brought
to the surface. This technique can provide patients with a detailed picture
of their parental attitudes, developmental periods, and relationships that
affected their body image. For eating-disordered men who tend to be focused
externally, guided imagery is especially powerful because it teaches patients to
look within and to trust their own responses. Finally, the symbolic nature of
imagery permits greater freedom of exploration into the highly charged area
of “body.”

The following two theme-centered guided imageries can be used to explore
the psychodynamic meaning of male eating-disordered patients’ preferred
body shape and their compulsion to rid their bodies of fat.

Guided Imagery: Meaning of Male Body Shapes

Van Der Velde (1985) hypothesizes that body image provides three social
functions. It enables men to project how others see them by means of their
appearance and actions; it enables them to control selectively the establish-
ment and preservation of a desirable view of themselves; it enables them to
create within others impressions that may not reflect their actual selves. We
developed the following guided imagery to allow men to examine the meaning of the three body types (V-shaped, thin, and fat) and to determine the deeper meaning of the particular image they are trying to project.

Patients are asked to imagine that when they wake up the next morning and look in the mirror, each one sees that his body has a thin, lean shape. They are asked to go through the day and to be aware of how it is to be in the world with this new body. They are instructed to watch how they eat, how they dress, how they move, how they interact with others, how others respond to them, and what they do with their free time. As they go through the day, they are asked to be aware of what their body says to their parents, to other males, to females, and so on before they open their mouth. (Examples: Does it say I am powerful, in control, out of control, masculine, feminine, virile, etc?) Do they act differently with a body of this particular shape?

The patients then are taken through the same imagery with the other two shapes (V-shaped and fat). Then they are asked to sculpt or draw the shape to which they aspire and to write the statement which that particular shape makes to the world about them. Finally, they discuss the meaning of this statement.

**Guided Imagery: The Meaning of Fat**

Sours (1980) speculates that fat means different things to males and to females. Whereas fat in a girl is likely to represent feminity (the development of breasts and hips), to a boy it is more apt to be related to thoughts of babyhood, weakness. Sours states that the presence of gender confusion helps to explain the increased seriousness of anorexia when it does occur in males, because increased identification with the mother would decrease the ability to differentiate self from mother and would increase the identification with the mother’s rounded body shape. This fear of identification would lead, in turn, to controlling vigorously any hint of fat.

In an attempt to clarify the psychodynamic meaning of “fat” for eating-disordered men so they might be able to view weight gain more realistically, we have developed the following imagery.

The patients are asked to imagine that he is given a magic laser which can remove all the fat from his body painlessly. Then he is asked to visualize his body and use the laser to rid the body of fat. He is to see the fat dropping off him and landing in front of him in a puddle. How does he feel as he looks at the fat in the puddle? Is he relieved to experience it as separate from him or does he miss it?

Now this fat in the puddle is coming to life and taking shape. What does it turn into? What does this newly formed animal, person, or object do? What does it say about itself? Does it remind him of his mother, from whom he struggles to separate? Is it a burden?

The fat now melts back into the puddle. The patient has a choice: to leave the fat behind, to integrate it back into his body, or to carry it with him in a sack. How does he feel about his choice? What will he lose and what will he gain with this choice?

After the imagery is completed, the patient is asked to draw what the fat turned into during the imagery. Under the drawing he is asked to write a description of what it turned into (what it looked like physically, how it acted during the imagery, and how it responded to the patient’s decision at the end of the imagery). Then the patient is asked to discuss the possible meaning of “fat” for him.

**SUMMARY**

Although the subject of eating disorders has received a great deal of attention in both popular and scholarly literature, research on males with eating disorders is limited. Culturally, men may be less subject to the factors which move women toward eating disorders, but they are not immune to the present emphasis on fitness and dieting or to the kind of underlying psychopathology which provides the foundation for the symptoms of eating disorders. Thus, more attention to the male eating-disordered patient is warranted.

The role of personality organization and functioning in eating disorders has not been fully established. Some theorists suggest that personality factors may play a more important role in the development of eating disorders in men than in women (Andersen, 1988), but empirical studies addressing this hypothesis do not exist. In this study, males with eating disorders did not score in the psychopathological range for personality disorders (such as borderline or narcissistic), but did emerge with a personality style characterized by dependency, avoidance, and passive-aggressiveness.

In this chapter, the authors offer some suggestions for the treatment of body image disturbance among eating-disordered patients. More research is needed for the development and evaluation of techniques to treat body image disturbance. Better understanding of the ways in which the image and functions of the body are employed in psychic conflict offers the possibility of enhancing the conceptualization and treatment of eating disorders. Whether
the value of the treatment lies in the resolving of body image disturbance per se or in the psychodynamic issues which emerge through the body image work, further development of techniques is warranted. In addition, the role of body image parameters in mediating outcomes of treatments for males with eating disorders remains fertile ground for scientific study.

The study described in this chapter is descriptive; it does not purport to make conclusive statements regarding the etiology of eating disorders in men. Instead it provides information on the body image concerns of normal and eating-disordered men and offers a preliminary risk factor model which needs further validation. These preliminary results must be viewed with caution because of the correlational nature of the data and the small sample size of the clinical group. In the future, it would be advisable to validate these results with additional measures and a broader population.

REFERENCES


Appendix C

AN OVERVIEW OF ANOREXIA NERVOSA IN MALES

Tom Wooldridge and Pauline "Polly" Lytle

This chapter presents an integrative overview of existing research on anorexia nervosa (AN) in adolescent males. AN is commonly thought of as a female disorder. Even though as much as 25 percent of the clinical population is male, research on AN in males is limited. Additionally, most conceptualizations of male AN emphasize a single etiological factor and, therefore, produce treatments that fail to address it as a global phenomenon. In contrast, an integrative understanding that incorporates research on the familial, biological, cultural, and psychodynamic elements involved in male AN encourages treatment that comprehensively addresses the disorder.

Introduction

Anorexia nervosa (AN) is thought of as an almost exclusively female disorder. As a result, the majority of research on AN has focused on women. However, epidemiological data suggest that as much as 25 percent of the population is male (Hudson, Hiripi, Pope, & Kessler, 2007). Furthermore, there are reasons to think that many men with AN are overlooked during differential diagnosis (Andersen, 1990; Crisp & Burns, 1990). In short, AN in males demands the attention of researchers and clinicians.

This chapter presents an integrative understanding of male AN. Drawing from research on the familial, biological, cultural, and psychodynamic factors that contribute to the genesis and maintenance of male AN, this chapter synthesizes research on AN in males into an integrative framework based on Pinsof’s (1995) integrative problem-centered therapy.
Integrative Problem-Centered Therapy

Integrative problem-centered therapy provides a way to organize information from research in multiple areas of psychology about a presenting problem into a single, unified understanding of how to solve that problem (Pinsof, 1995). In integrative problem-centered therapy, a problem-maintenance space helps to visualize the patient's presenting problem. The problem-maintenance space is a set of six levels, each representing a particular domain of activity and containing a metamodel for that domain (Pinsof, 1995). Metamodels integrate diverse theories that relate to a particular domain of activity (Bruning, Schwartz, & Mac Kinnon-Kalmar, 1992). Because of the limited research available about AN in males, our model the problem-maintenance space consists of four levels. This problem-maintenance space is shown in Table 3.1.

The Family System metamodel explores the rules that determine how members of the patient system relate to each other. Second, the Biological metamodel recognizes that biological factors can limit the ability of key members of the patient system to solve the presenting problem. Third, the Meaning (Culture and Gender) metamodel emphasizes the meaning, both cognitive and affective, that members of the patient system attribute to themselves, each other, and their behavior. This metamodel recognizes the importance of both culture and gender in the meaning-making process. Finally, the Psychodynamic metamodel conceptualizes the self and its constituent subsystems, such as the ego, within the language of object relations.

An Integrative Model of AN in Adolescent Males

Family Systems

Because our first exposure to the social aspects of eating is in the family, it is unsurprising that certain factors in the family are tied to the development of AN (Annus, Smith, Fischer, Hendricks, & Williams, 2007). As a result, knowledge about families of individuals with AN has a significant impact on the prevention and treatment of AN (Eagles, Johnston, & Millar, 2005). Unfortunately, past research has focused on the families of adolescent girls with AN and on the mother–daughter relationship in particular. However, knowledge about the families of adolescent boys may provide important information for successful treatment (May, Kim, McHale, & Crouter, 2006).

Commonalities are found in the family systems of males with AN. In a longitudinal study spanning 9 years, Lindblad, Lindberg, and Hjern (2006) found that boys and men with AN are significantly more likely to live in a single-parent home. This study is supported by another, which found that fathers of boys with AN were more likely to live separately or have died (Nelson, Hughes, Katz, & Searight, 1999).

Several patterns of family interaction predict the development of AN, such as less independence and autonomy (Fekler & Silver, 1994). Supporting this finding, Romano (1994) reported that many mothers of males with AN are overly controlling and protective. Because boys with controlling and protective mothers lack the experience necessary to gain confidence for self-initiated behavior, they are unable to cope with the demands of adolescence. As a result, the boys' independence is compromised.

Fekler and Silver (1994) also reported that greater conflict, control, and achievement orientation were linked with risk for developing AN. In support of this idea, Sterling and Segal (1985) reported strong indications of excessive parental expectations for male children who develop AN. In another study, several males with AN stated that their fathers pressured them to excel in sports or to have a muscular physique (Romero, 1994).

Although a few studies cannot yield conclusive evidence about which family interactions are risk factors for AN, these findings point to the need for further research.

Biological

Biological factors must be accounted for to fully understand AN in adolescent boys. In males with AN, malnutrition leads to considerable disturbance in the endocrine system. This disturbance is similar to the dysfunction behind amenorrhea in females (Heinz, Bradburn, & Newman, 1990). In one study, Andersen and Mickalide (1983) found that 2 out of 10 males with AN were infertile due to endocrine changes secondary to weight loss. Elsewhere, Lemaire et al. (1985) found that plasma testosterone, serum follicle-stimulating hormone (FSH), serum luteinizing hormone (LH), and response to luteinizing hormone-releasing hormone (LHRH) were lower than normal in males with AN. As subjects' weights rose, plasma testosterone, FSH, LH, and response to LHRH increased. In particular, increases in serum testosterone were correlated with weight.
gain. Similar results have been reported by other researchers (Beumont et al., 1972; Crisp, Hau, Chen, & Wheeler, 2006).

In each of these studies, testosterone levels remained significantly lower than normal even after weight restoration in many subjects. In fact, researchers have suggested testosterone replacement for males in these cases (MeOhler, Philip, Andersen, & Arnold, 1999). Regardless, factors other than malnutrition must account for low testosterone levels in males with AN (Lemaire et al., 1983). According to Herzog, Bradburn, and Newman (1990), a similar process takes place in females who are slow to recover menstruation after weight restoration. They suggested that these women continue abnormal and unhealthy eating behavior regardless of restored body weight, which interferes with their recovery of healthy menstrual functioning. Whether a similar process is taking place in males who fail to recover normal testosterone levels requires further investigation.

Although osteoporosis is widely recognized as a risk factor in females with AN, it is often forgotten in males (MeOhler et al., 1999). Indeed, in the general population, 80 percent of those affected by osteoporosis are women (National Osteoporosis Foundation, 2009). One protective factor against osteoporosis in males is their higher testosterone levels. However, males with AN have significantly lower testosterone levels. As a result, males with AN are at least as likely to develop osteoporosis as their female counterparts (MeOhler et al., 1999). For example, Scurlock, Timimi, and Robinson (1997) reported the case of a 38-year-old male with AN who developed severe osteoporosis. Males with AN, particularly those with the binge–purge subtype, may be at greater risk for osteoporosis than matched females ("Men with eating disorders at high risk of osteoporosis," 2008).

Pre-morbid obesity is another important biological component of male AN. While girls diet because they feel fat, boys may diet because they have been overweight at some point in their lives (Andersen, 1992). In a study of 13 males with AN, Crisp and Toms (1972) found that the mean weight just before onset of AN was 114 percent matched population mean weight. Other researchers have reported similar findings (Andersen, 1990; Sharp, Clark, Duncan, Blackwood, & Shapiro, 1999).

Puberty plays a role in the development of AN in males. In most boys with AN, onset starts just before or after puberty begins (Scott, 1986). Entry into puberty causes significant weight gain. If puberty happens early and quickly, boys may become slightly overweight for their age. As mentioned, although not all males are obese before the onset of AN, many are overweight. In fact, the idea that rapid onset of early puberty is a risk factor for AN is supported by the fact that AN is most prevalent in females. In comparison to boys, females experience puberty earlier and have rapid growth with a marked increase in body fat relative to muscle (Crisp &

### ANOREXIA NERVOSA IN MALES

Burns, 1990). This may be one reason that adolescent girls are more likely to develop AN than their male counterparts.

#### Meaning (Culture and Gender)

The meaning, both cognitive and affective, that clients attribute to themselves, each other, and their behavior is often intertwined with their struggle with AN. Schilder (1953) was the first to consider bodily experience from a psychological and sociological point of view, defining body image as the picture of ourselves we form in our own minds. According to this definition, body image is subjective. There may be little correlation between one's experience of the body and its outside appearance. One study found that the body ideals of males with AN were no different than the body ideals of controls. However, males with AN perceived themselves as almost twice as fat as they actually were. If this finding is robust, males with eating disorders might not need to be re-educated about the levels of body fat that are appropriate; on the contrary, it may be that their perceptions of their own bodies require revision (Mangweri et al., 2004).

Body image is also shaped by social and cultural factors. Garfinkel and Garner (1982) found that social experience encourages a thin body shape model in females with AN. Now, evidence increasingly suggests that our society encourages a problematic body shape model in boys, too. In popular culture, male bodies are presented as muscular and trim (Andersen & DiDomenico, 1992). The number of magazines that emphasize men's appearance has increased extraordinarily (Bonni, 2002). Advertisements depict men as sexual objects (Kimmel & Tausig-Dubordes, 1999). Even children's action figures have become more muscular (Xie et al., 2006).

As these sociocultural changes have taken root, young men have experienced increasing body dissatisfaction (Adams, Turner, & Bucks, 2005). This increase in body dissatisfaction may stem from greater exposure to ideal bodies in popular culture (Morrison & Morrison, 2003; Pope, Phillips, & Olivardia, 2000). A recent meta-analysis of 15 studies found that exposure to images of ideal male bodies has a small but statistically significant negative effect on young men's body satisfaction (Blond, 2008).

Males with AN often have a history of weight-related teasing (Andersen, Cohn, & Holbrook, 2000). Perhaps due to the fact that they are often slightly overweight, these boys may be hypersensitive to teasing about "plumpness" or "pudginess" (Sterling & Segal, 1985). Peer criticism about weight was reported as a precipitating factor in several studies (e.g., Sharp et al., 1994).

Involvement with high-risk groups also increases the tendency for adolescent boys to develop AN. For example, Carlat, Camargo, and Herzog (1997) found that in a sample of 169 males with eating disorders,
17 (16 percent) were in high-risk jobs, including appearance-based jobs (e.g., modeling, acting), jobs traditionally held by women (e.g., floriculture, nursing), and food-related jobs (e.g., catering, restaurant management). In spite of its potential benefits, athletics may lead to the development of eating disorders. AN is prevalent in sports where aesthetics are critical to the scoring process or where weight is an important factor in optimum performance or a requirement for participation. These include figure skating, diving, dance, gymnastics, body building, wrestling, horse racing, and running (Andersen, Bartlett, Morgan, & Brownell, 1993; Baum, 2006).

Homosexuality has been identified as a risk factor for eating disorders in men (Andersen, 1990). The percentage of homosexuals in the population of males with eating disorders is likely twice as high as in the general population (Frichter & Daser, 1987). The most widespread explanation for the increased incidence of AN in the homosexual population is that gay men experience more body dissatisfaction than heterosexual men (Andersen et al., 2000; Beren, Hayden, Willey, and Grilo, 1996). Indeed, homosexual men experience a cultural pressure to remain thin, similar to the pressure experienced by women. In one study, men in the gay community reported more pressure to diet (Herzog et al., 1990). Gay men also reported more general and weight-specific teasing than any other group (Beren et al., 1996).

Researchers have also suggested that gay and bisexual men are at increased risk for eating disorders because of the greater incidence of childhood sexual abuse in this population (Feldman & Meyer, 2007). According to Hund and Espelage (2006), eating disorders develop as an attempt to cope with the emotions associated with abuse. Furthermore, the association between childhood abuse and eating disorders has been reported in men (Neumark-Sztainer, Story, Hannan, Beuhring, & Resnick, 2000).

**Psychodynamic**

Hilde Bruch was the first person to describe AN in the language of object relations. As a result, modern dynamic formulations of AN cite disturbances in the early mother–child relationship that predispose children to develop AN during adolescence (Humphrey, 1991). Bruch believed that over-involved caretakers are part of this development. In a study of 9 male patients with AN, Bruch (1971) observed that a controlling mother imposed on the developing child her own concepts of the child’s needs and desires. This enmeshed dynamic ran smoothly until the children reached adolescence, when their demand for separation and individuation disrupted the status quo.

According to Bruch (1971), children who grow up with over-involved caretakers function well until a situation demands independent decision-making and self-initiated behavior. Bruch observed that boys with AN were almost always success- and achievement-oriented. In many cases, the onset of AN began when their superior status was threatened or when they began to have serious doubts about their competence.

At this point, AN began to serve an adaptive function for these children, as an effort to take charge of themselves by controlling their bodies. However, changes in the body and its size cannot provide a real sense of self-directed identity, and their pursuit of thinness became increasingly frantic and extreme (Bruch, 1971). At the same time, self-starvation is an oppositional behavior that, at the superficial level, disrupts the symbiotic relationship between caretaker and child (Johnson, 1991). Self-starvation was an attempt both to develop autonomy and defend against further maternal intrusiveness.

Perfectionism has also been shown to be characteristic of many eating disorders. It is a risk factor for the development of AN in both men and women (Pebush, Heatherton, & Keel, 2007). According to one study, nearly a third of 24 males with AN reported having conscientious and obsessive pre-morbid characteristics as children (Sharp et al., 1993). Serling and Segal (1985) suggested that higher levels of perfectionism were associated with a lifetime history of fasting in males.

Conflict about sexual identity may also play a role in male AN. Early on, researchers suggested that sexual development plays an important role in male AN. Burns and Crisp (1983) found that active sexual fantasy, masturbation, and general sexual activity were strong predictors of good recovery in males with AN. In another study, Herzog, Norman, Gordan, and Pepote (1984) found that males with eating disorders were significantly more likely to have had no sexual relations and to report being homosexual. They were significantly less likely to be involved in an active heterosexual relationship.

Most adolescents with AN lose their sexual drive (Crisp & Burns, 1983; Hall, Delahun, & Ellis, 1985). In general, males with AN experience diminished sexual desire and performance. In part, this is a result of diminished levels of testosterone and other sex-related hormones (Herzog et al., 1990). Diminished sexual desire has a secondary gain for males with AN. Indeed, Crisp and Burns (1983) noted that few males with AN complain about their lack of sexual drive. Romero (1994) stated that many males with AN are retreating from the pressure to establish a male sexual identity. Similarly, researchers have suggested that some males with AN experience pre-morbid homosexual panic (Crisp, 1967; Dally, 1979).
Conclusion

This chapter began with the recognition that a significant number of adolescent males struggle with AN. Because AN is thought of as a female disorder, however, the majority of research has focused on understanding and treating the disorder in girls and women. Furthermore, most conceptualizations of AN in males emphasize a single etiological factor. In contrast, an integrative understanding brings together knowledge about AN to encourage treatment that addresses it as a global phenomenon (Andersen, 1990).

We have attempted to provide an integrative overview of AN in adolescent males. While application of this approach in clinical practice has been discussed in Wooldridge (2009), the information presented here is hoped to help clinicians begin to understand their patients from a multi-dimensional perspective, informed by the latest research.

References


TOM WOOLDRIDGE AND PAULINE LYTLE


ANOREXIA NERVOSA IN MALES


Appendix D: Call-Out Flyer for Participants

**Do you identify as male?**

**Do you identify as eating-disordered?**

**Are you willing to share your stories?**

Description of Project:
This research study aims to provide a forum in which men with eating disorders (EDs) can relate their experiences for the purposes of self-representation. Male bodies and narratives have been largely missing in the literature around EDs, and much of the research has been quantitative in nature. This study asks participants to reflect on their memories of food and eating, and to discuss their experiences with EDs using their own words and associations. The purpose of the research is to give others an insight into this invisible population, and to create more awareness in the medical and psychiatric communities, and beyond.

Nature of Participation:
The study will be conducted through one-on-one, open-ended interviews (roughly 1-2 hours in length) between you and the researcher in a private location. You will be informed about any potential emotional or psychological risks prior to the data collection process, and asked to sign a consent form. All names and identifying markers will be altered in the study for the purposes of protecting privacy and respecting confidentiality.

Compensation for your participation will be provided, as well as reimbursement for any commuting costs (TTC tokens)

**Research Study:** Nourishing Hunger: Narratives of Eating Disorders by Men  
**Department:** Sociology and Equity Studies, OISE

Please contact Yaseen for more details at yaseen.ali@mail.utoronto.ca

Participants can contact the Office of Research Ethics at ethics.review@utoronto.ca or 416-946-3273 if they have any questions about their rights as participants.
Appendix E: Interview Questions

Note: These questions are meant to evoke narratives around EDs without referencing the specific condition itself (e.g. “Are you anorexic?” or “When did your ED begin?”).

This open-ended approach to asking questions (outlined below) is meant to achieve the following: using ostensibly benign prompts to have the interviewees bring up the relevant data themselves.

My concern is that directly discussing the ED would orient the participants’ responses to follow certain narratives they have absorbed from elsewhere (i.e. in treatment, therapy, etc). My goal is to have the participants use their own words to talk about their experiences, rather than use the language of the clinic.

Prompts may include all or some of the following:

- What is your earliest memory of consuming food?
- When did you learn to eat?
- How did you learn to eat?
- How do you experience hunger?
- What is your earliest memory of becoming aware of your body?
- What is a healthy body?

Once the participants began to articulate a narrative, I would step in and ask for clarification whenever necessary. I would also freely employ the words “diet”, “anorexia”, “bulimia”, “body image”, etc, once mentioned by the participant.
Appendix F: REB (Research Ethics Board) Approval and G: Renewals

-----Original Message-----
From: ethics.review@utoronto.ca [mailto:ethics.review@utoronto.ca]
Sent: May 11, 2012 8:01 PM
To: tanyatitchkosky@oise.utoronto.ca; yaseen.yusufali@utoronto.ca
Cc: Dario Kuzmanovic
Subject: Ethics Approval Letter - Protocol ID 27538 (EP0002753820120511180035OAF)

PROTOCOL REFERENCE # 27538

May 11, 2012

Dr. Tanya Titchkosky  Mr. Yaseen-Ali Yusufali
DEPT OF SOCIOLOGY & EQUITY STUD, INDEPT OF SOCIOLOGY & EQUITY STUD, IN
EDUC. EDUC.
OISE/UT OISE/UT

Dear Dr. Titchkosky and Mr. Yaseen-Ali Yusufali,

Re: Your research protocol entitled, "Nourishing hunger: Narratives of eating disorders by men"

ETHICS APPROVAL  Original Approval Date: May 11, 2012
  Expiry Date: May 10, 2013
  Continuing Review Level: 2

We are writing to advise you that the Social Sciences and Humanities Research Ethics Board (REB) has granted approval to the above-named research protocol, for a period of one year. Ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Margaret Schneider, Ph.D.,       Dean Sharpe, Ph.D.
C.Psych                         REB Manager
REB Chair

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Dr. Tanya Titchkosky  
DEPT OF SOCIOLOGY & EQUITY STUD. IN EDUC.  
OISE/UT  

Mr. Yaseen-Ali Yusufali  
DEPT OF SOCIOLOGY & EQUITY STUD. IN EDUC.  
OISE/UT  

Dear Dr. Titchkosky and Mr. Yaseen-Ali Yusufali,

Re: Your research protocol entitled, "Nourishing hunger: Narratives of eating disorders by men"

ETHICS APPROVAL  

Original Approval Date: May 11, 2012  
Expiry Date: May 10, 2014  
Continuing Review Level: 2  
Renewal: 1 of 4  

We are writing to advise you that you have been granted annual renewal of ethics approval to the above-referenced research protocol through the Research Ethics Board (REB) full board review process. Please note that all protocols involving ongoing data collection or interaction with human participants are subject to re-evaluation after 5 years. Ongoing research under this protocol must be renewed prior to the expiry date.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your protocol. Note that annual renewals for protocols cannot be accepted more than 30 days prior to the date of expiry as per our guidelines.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible. If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Sarah Wakefield, Ph.D. REB Chair  

Dean Sharpe REB Manager
Dear Dr. Titchkosky and Mr. Yaseen-Ali Yusufali,

Re: Your research protocol entitled, "Nourishing hunger: Narratives of eating disorders by men"

We are writing to advise you that you have been granted annual renewal of ethics approval to the above-referenced research protocol through the Research Ethics Board (REB) delegated process. Please note that all protocols involving ongoing data collection or interaction with human participants are subject to re-evaluation after 5 years. Ongoing research under this protocol must be renewed prior to the expiry date.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your protocol. Note that annual renewals for protocols cannot be accepted more than 30 days prior to the date of expiry as per our guidelines.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible. If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,
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Tel: +1 416 946-3273  Fax: +1 416 946-5763  ethics.review@utoronto.ca  http://www.research.utoronto.ca/for-researchers-administrators/ethics/