

A NEEDS ASSESSMENT:
RESOURCES FOR MALES
WITH EATING DISORDERS

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By

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ABSTRACT

Approximately 5-10% of all identified eating disorders occur in males. The purposes of this study were to identify resources currently available to males with eating disorders and define what additional resources are needed for support, education, prevention, and recovery. Three research questions guided the study: what treatment resources and educational programs are available in Canada that are geared specifically to males with eating disorders, what do health professionals who work with eating disordered adolescents and adults identify is needed for treatment resources and education for males with eating disorders, and what do males who have anorexia nervosa or bulimia nervosa identify as being useful, relevant, and accessible to them in terms of treatment resources and education?

Qualitative needs assessment methodology was used, which included three phases: pre-assessment, assessment, and post-assessment. Reflexive journal, peer debriefing, member checking, and feedback were also used. A thorough search of eating disorders resources specific to males was conducted through contacts with government and organizations. Fifteen health professionals who work with eating disorders and eight males with anorexia or bulimia (ages 18-42) were interviewed regarding their knowledge and use of treatment and information resources for eating disorders. The health professionals varied in their experience with male eating disorder clients. The males varied in stage and severity of their eating disorder; three men had anorexia, three men had bulimia, one man had both, and one man was pre-anorexic. Results of the resource search showed scattered availability of male specific written information and treatment programs across Canada. There were several combination and non-gender specific resources and educational programs available for use with male eating disorder issues. The internet provided websites (Canadian and international) that contained male specific and general eating disorders information. The health professionals and the male eating disorder participants discussed a number of main

themes related to resources, including format and design, focus, access and location, gender specificity, support groups, nutrition information, internet, and personal and community support. There were very specific suggestions from participants for treatment and information resources to be developed. Both the health professionals and the males identified a number of barriers related to resource access and use; these included failure to recognize the eating disorder by health professionals, family and friends, and men themselves, the perception that eating disorders are a “female disease,” the need to live up to a “strong man” image, and a sense of isolation. Feedback interviews with three of the men reinforced this input.

The implications of this research for health professionals include the need for further self-education about males with eating disorders and recognition of the signs in male clients. For men with eating disorders, the implications lie in becoming aware of available treatment options and written information. Recommendations for developing resources include increasing awareness of eating disorders in men and using gender neutral resources for eating disorders education. Overcoming barriers to increase resource accessibility for males includes communicating availability, encouraging males to come forward with eating problems, and educating the public on eating disorders.

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Dedication

To my father, who continues to guide me and who I think of every day. You are always with me.

To my mother and brother, thank you for your encouragement and love and for keeping me on track.

And to Chris - I would not have been able to complete this project without your love and support. I draw my strength from you. Your intelligence inspires me. Thank you for staying sane and keeping me that way.

Table of Contents

| | |
|--|----|
| PERMISSION TO USE | i |
| ABSTRACT | ii |
| ACKNOWLEDGEMENTS | iv |
| DEDICATION | v |
| TABLE OF CONTENTS | vi |
| 1. INTRODUCTION | 1 |
| 1.1 Problem Statement | 1 |
| 1.2 Context for the Research | 1 |
| 1.3 Purpose of Study | 2 |
| 1.4 Significance of the Research | 3 |
| 1.5 Research Questions | 3 |
| 1.6 Assumptions | 3 |
| 1.7 Scope and Factors Associated with the Study | 4 |
| 1.8 Ethical Considerations | 4 |
| 1.9 Definition of Terms | 6 |
| 1.10 Summary | 7 |
| 2. REVIEW OF THE LITERATURE | 8 |
| 2.1 General Characteristics of Males with Eating Disorders | 8 |
| 2.2 Adolescent and Adult Males with Anorexia Nervosa | 10 |
| 2.3 Adolescent and Adult Males with Bulimia Nervosa | 12 |
| 2.4 Body Image Concerns of Men | 13 |
| 2.5 Males, Dieting Behavior, and Weight Control | 16 |
| 2.6 Body Image, Eating Disorders, and Athletics | 18 |
| 2.7 Comparing Males and Females with Eating Disorders | 23 |
| 2.8 Relationship of Anorexia Nervosa and Bulimia Nervosa | 27 |
| to Homosexuality | |
| 2.9 Factors Affecting Incidence and Identification of Eating | 30 |
| Disorders in Males: Low Prevalence or Low Identification? | |
| 2.10 Approaches to Addressing Eating Disorders in Males | 32 |
| 2.11 Issues in Eating Disorders Resource Use | 37 |
| 2.12 Summary | 39 |

| | | |
|---------|--|----|
| 3. | METHODOLOGY | 41 |
| 3.1 | Qualitative Design | 41 |
| 3.1.1 | Paradigm Rationale and Assumptions | 41 |
| 3.1.2 | Needs Assessment Methodology | 42 |
| 3.1.3 | Interviewing as Knowledge Inquiry | 44 |
| 3.1.4 | Interviewer Skills | 44 |
| 3.1.5 | Triangulation of Data | 46 |
| 3.2 | Researcher's Story | 46 |
| 3.3 | Research Design and Data Collection Procedures | 50 |
| 3.3.1 | Description of Target Group | 50 |
| 3.3.1.1 | Criteria for Participation | 50 |
| 3.3.2 | Needs Assessment Design | 51 |
| 3.3.3 | Resource Search Design | 52 |
| 3.3.3.1 | Documentation of Eating Disorder | 52 |
| | Resources | |
| 3.3.3.2 | Resource Search Contacts | 53 |
| 3.3.4 | Health Professionals | 54 |
| 3.3.5 | Males with AN and/or BN | 56 |
| 3.3.6 | Interview Recording Procedures | 58 |
| 3.3.7 | Reflexive Journal | 59 |
| 3.4 | Data Analysis | 60 |
| 3.5 | Methods of Verification | 62 |
| 3.5.1 | Credibility | 62 |
| 3.5.2 | Transferability | 63 |
| 3.5.3 | Dependability | 64 |
| 3.5.4 | Confirmability | 64 |
| 3.5.5 | Audit | 65 |
| 3.6 | Ethical Approval | 66 |
| 3.7 | Summary | 66 |
| 4. | RESULTS AND DISCUSSION | 67 |
| 4.1 | Description of Research Participants | 67 |
| 4.1.1 | Health Professional Participants | 67 |
| 4.1.2 | Male Eating Disorder Participants | 68 |
| 4.2 | Resource Availability in Canada | 71 |
| 4.2.1 | Male Specific Resources | 71 |
| 4.2.2 | Combination and Non-Gender Specific Resources | 72 |
| 4.2.3 | Beyond the Identified Resources | 73 |
| 4.2.4 | Internet | 74 |
| 4.3 | Resource Needs and Issues | 75 |
| 4.3.1 | Format and Design | 75 |

| | | |
|---------|---|-----|
| 4.3.2 | Focus | 78 |
| 4.3.2.1 | Target Groups | 78 |
| 4.3.2.2 | Types of Information | 83 |
| 4.3.2.3 | Promoting Males to Come Forward | 85 |
| 4.3.3 | Access and Location | 87 |
| 4.3.3.1 | Knowledge and Source of Resources | 87 |
| 4.3.3.2 | Communicating Availability | 88 |
| 4.3.3.3 | Presentation of Information to Clients | 90 |
| 4.3.3.4 | Anonymity and Privacy | 91 |
| 4.3.3.5 | Location | 93 |
| 4.3.4 | Gender Specificity | 94 |
| 4.3.4.1 | Male Specific Resources | 95 |
| 4.3.4.2 | Female Specific Resources | 97 |
| 4.3.4.3 | Non-Gender Specific Resources | 99 |
| 4.3.5 | Support groups | 101 |
| 4.3.5.1 | Gender-Mix of Support Groups | 102 |
| 4.3.5.2 | Problems and Issues | 103 |
| 4.3.6 | Nutrition Information | 105 |
| 4.3.6.1 | Benefits of Nutrition Information | 106 |
| 4.3.6.2 | Drawbacks of Nutrition Information | 107 |
| 4.3.7 | Internet | 109 |
| 4.3.7.1 | Types of Internet Information | 109 |
| 4.3.7.2 | Benefits of Using the Internet | 110 |
| 4.3.7.3 | Drawbacks of Using the Internet | 112 |
| 4.3.8 | Personal and Community Support | 112 |
| 4.3.8.1 | Disclosure Issues | 113 |
| 4.3.8.2 | Support Networks | 114 |
| 4.3.9 | Suggestions for Developing Treatment and Information Resources | 116 |
| 4.3.9.1 | Suggestions from the Men | 116 |
| 4.3.9.2 | Suggestions from the Health Professionals | 122 |
| 4.4 | Barriers Related to Resource Access and Use | 126 |
| 4.4.1 | Recognition of the Eating Disorder | 126 |
| 4.4.1.1 | Recognition by Friends and Family | 127 |
| 4.4.1.2 | Recognition by Health Professionals | 129 |
| 4.4.1.3 | Recognition by Men Themselves | 131 |
| 4.4.2 | The “Female Disease” | 134 |
| 4.4.3 | The “Strong Man” Bluff | 136 |
| 4.4.4 | Isolation | 141 |
| 4.5 | Results from the Feedback Process | 142 |
| 4.5.1 | Format and Design | 143 |
| 4.5.2 | Gender Specificity | 143 |
| 4.5.3 | Nutrition Information | 145 |

| | | |
|------------|---|-----|
| 4.6 | Summary | 145 |
| 5. | SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS | 148 |
| 5.1 | Summary by Research Question | 148 |
| 5.2 | Implications for Health Professionals | 152 |
| 5.3 | Implications for Males with Eating Disorders | 154 |
| 5.4 | Recommendations | 155 |
| 5.4.1 | Resources to be Developed | 155 |
| 5.4.1.1 | General Directions | 155 |
| 5.4.1.2 | Specific Resource Types | 156 |
| 5.4.2 | Overcoming Barriers to Make Resources More Accessible | 158 |
| 5.5 | Limitations | 160 |
| 5.6 | Areas for Further Research | 161 |
| | REFERENCES | 163 |
| APPENDICES | | |
| A - | Diagnostic Criteria for Anorexia Nervosa and Bulimia Nervosa | 175 |
| B - | Qualitative and Quantitative Paradigm Assumptions | 177 |
| C - | Resource Description Form | 178 |
| D - | List of Organizations Contacted for Resources | 179 |
| E - | Cover Letter for Health Professional Recruitment | 182 |
| F - | Cover Letter for Health Professional Phone Interviews | 184 |
| G - | Interview Guide for Health Professionals | 186 |
| | (Groups and Individual Interviews) | |
| H - | Consent Form for Health Professional Group Interviews | 188 |
| I - | Consent Form for Individual Health Professional Interviews | 189 |
| J - | Cover Letter for Male Eating Disorder Participant Recruitment | 190 |
| K - | Interview Guide for Male Eating Disorder Participants | 192 |
| | (Initial Interview) | |

| | |
|---|-----|
| L - Consent Form for Eating Disorder Initial Interviews | 193 |
| M - Cover Letter to Describe Feedback Options for Male Eating Disorder Participants | 194 |
| N - Cover Letter for Male Eating Disorder Feedback Interviews | 196 |
| O - Interview Guide for Feedback Discussion with Male Eating Disorder Participants | 197 |
| P - Consent Form for Male Eating Disorder Feedback Interviews | 199 |
| Q - Feedback Report for Male Eating Disorder Participants | 200 |
| R - Audit Report | 203 |
| S - Confirmation of Ethical Approval | 205 |
| T - Profile of Health Professional Participants | 206 |
| U - Profile of Male Eating Disorder Participants | 207 |
| V - Resources Specific to Males and Disordered Eating | 208 |
| W - Non-Gender Specific or Combination Resources That Can Be Used for Males and Disordered Eating | 213 |
| X - List of Internet Sites with Information on Males and Eating Disorders | 217 |

Chapter 1 - Introduction

1.1 Problem Statement

Anorexia nervosa (AN) occurs at a 1:20 male to female ratio, and bulimia nervosa (BN) at a 1:10 ratio (Woodside, 1993). Although this represents a relatively small number of males who may be suffering from an eating disorder, they are a group who have specific concerns related to body image, self esteem, and weight. Health promotion and disease prevention strategies for eating disorders may include support and educational programs that are needed to help them cope with their illness. Treatment measures may include medical interventions and therapy.

However, little is known about the specific treatment and information resources that are needed for adolescent and adult males to cope with an eating disorder. This research aims to study the need for educational and support resources for adolescent and adult males with anorexia nervosa and bulimia nervosa.

1.2 Context for the Research

The availability of treatment and information resources for individuals with eating disorders is important for effectively addressing an eating disorder. Providing information and referrals regarding available services and treatment options empowers the individual to make an informed choice (Bear, 1996) and increases the chances of a favorable outcome (Andersen, 1984). The development of specific interventions to address eating disorder issues can contribute the improvements in individual health. For example, cognitive-behavioral interventions can enhance body satisfaction, reduce focus on appearance and physical “ideals”, and promote improvement in eating disturbances and psychosocial

functioning (improvements in mental health and social capabilities) (Muth & Cash, 1997).

Lack of public and medical awareness of the problem of eating disorders in males may contribute to a delay for males in obtaining treatment (Margo, 1987). Education is an important strategy for educators and health professionals for the prevention and early detection of eating problems (Cohen, 1997). Advancing research efforts, developing prevention strategies, and keeping on top of literature allows the health educator to fulfill roles associated with eating disorders prevention, such as public education and communication of the warning signs of anorexia and bulimia (Felker & Stivers, 1994).

A joint committee on Services for Individuals with Eating Disorders compiled a report to the Deputy Minister of Saskatchewan Health in 1995 which made recommendations for eating disorder service and resource needs for individuals with eating disorders. They indicated gaps in service, problems in follow-up and support services for patients returning to province, and the need to enhance professionals' knowledge to assist them with assessment, diagnosis, and treatment. The report also indicated that individuals found it difficult to find help for their eating disorder and that the stigma attached to eating disorders affects the whole family. Recommendations included staff training to enhance knowledge, support groups, prevention and early intervention, and holistic programs (including family, peer counseling, nutritional therapy, and community follow-up). The joint committee supported the development of additional treatment and information resources as critical for addressing eating disorders (Saskatchewan Health, 1995).

1.3 Purpose of the Study

The purpose of this study was to identify resources currently available to males with eating disorders, and to define what additional resources and programs are needed for support, education, prevention, and recovery.

1.4 Significance of the Research

As media attention continues to focus on “perfect” body shapes and flawless looks, there is increasing pressure on males to “fit” a certain image. Lack of specific interventions and resources geared towards males with AN and BN may be perceived by them as an indication that they may not be respected in dealing with specific male issues concerning body image and self-esteem. Involving males who have an eating disorder in the evaluation of current literature and resources may empower them to seek support and become involved in awareness education and implementation of health promotion programs. Awareness of the discrepancies between current need and availability of treatment and information resources will provide valuable knowledge to health professionals considering the development and implementation of programs for eating disorders.

1.5 Research Questions

Main Question

What is the nature of the experiences with available resources of males with eating disorders and associated health care professionals?

Subsidiary Questions

1. What treatment resources and educational programs are available in Canada that are geared specifically to males with eating disorders?
2. What do health professionals who work with adolescents and adults with eating disorders identify is needed for treatment resources and education for males with eating disorders?
3. What do males who have anorexia nervosa or bulimia nervosa identify as being useful, relevant, and accessible to them in terms of treatment resources and education?

1.6 Assumptions

The following are some general assumptions about conducting a needs assessment for adolescent and adult males with an eating disorder:

- Males who are at risk of developing an eating disorder have specific issues to deal with and are at risk of becoming ill due to lack of tailored resources and education.
- The incidence of males with eating disorders is actually greater than the literature reports due to their hesitation in coming forward for treatment and support.
- Both health professionals and males with AN and BN see the issue of resource availability as warranting further research.

1.7 Scope and Factors Associated with the Study

Health professional participants were those who worked in Saskatchewan and who work with eating disorders treatment or education. All interviews with health professional participants were conducted in Saskatoon with the exception of telephone interviews done outside of the city. Males with eating disorders who were eligible for the study included those who had been identified by a health professional as having anorexia or bulimia and who lived in Saskatchewan. They may or may not have received current or past treatment for the eating disorder. All participants who were recruited lived in Saskatoon, and there was no travel outside the city for participant recruitment. Other males with eating disorders who came to my attention but who were unable to be contacted by health professionals were not included in the study.

1.8 Ethical Considerations

The need for extreme care of human participants in qualitative research, and the importance of avoiding any harm that the research process may bring, is crucial to conducting naturalistic inquiry (Fontana & Frey, 1994). Ethical concerns of informed consent, right to privacy, and protection from harm are important to consider (Fontana & Frey, 1994; Marshall & Rossman, 1989).

In the current study, it was crucial that the participants' therapy or treatment of eating

disorders not be interrupted. Subjects signed a consent form informing them of who would have access to the audio tapes and transcripts and assuring confidentiality. The number of individuals who knew the identity of the participants was limited to the researcher and the health professionals who recommended them. Trust was built between the researcher and the participants by avoiding invasive questions and developing personal rapport with participants. Processes for establishing trust included asking participants what they wanted out of the project, and how they wanted the research to progress. Researcher bias was avoided when asking questions - i.e., prompting answers. The revelation of personal information by the participants that resulted in unexpected emotional difficulties during the interviews was respected; opportunity to exit the interview at any time was provided (Renzetti & Lee, 1993).

The issue of confidentiality warranted extra attention by the researcher as the topic of eating disorders is an especially sensitive and private one. Participants must have confidence and the researcher must portray friendship and commitment to helping the participants (Punch, 1994). Settings and respondents are not identifiable in print. The researcher assured all participants complete confidentiality of their personal identity and the identity of what was said, both during and outside of interviews.

The health care professionals did not know “who said what” in the group of male eating disorder clients, or vice-versa. Confidentiality was a difficult issue due to the recruitment of male clients by the health professionals involved; however, what the individual males contributed was not revealed to them or any other health professional, thereby reassuring the participant and opening the doors for free sharing of information. Although the health professionals were interviewed in groups, “who said what” in one group was not discussed with the other groups, and individual group members were reminded of keeping the information revealed in the group session confidential.

1.9 Definition of Terms

Eating disorder - psychological or behavioural syndrome, characterized by severe disturbances in eating behaviour (American Psychiatric Association, 1994); extreme expressions of a range of weight and food issues (Eating Disorders Awareness and Prevention, Inc., 1995). For reference in this research proposal, the term “eating disorder” will refer to the conditions of anorexia nervosa and bulimia nervosa.

Anorexia nervosa (AN) - a psychoneurotic disorder characterized by a prolonged refusal to eat, resulting in emaciation, emotional disturbance concerning body image, and fear of becoming obese (Glanze, Anderson, & Anderson, 1990).

Bulimia nervosa (BN) - an insatiable craving for food, often resulting in episodes of continuous eating followed by periods of depression and self deprivation. Purging and use of exogenous substances (e.g., laxatives) are commonly used as a means of avoiding obesity (Glanze et. al., 1990).

Note: Refer to Appendix A for a copy of the Diagnostic Criteria for Anorexia Nervosa and Bulimia Nervosa.

Body image - a person's subjective concept of his or her physical appearance, realistic or unrealistic, resulting from self-observation, reactions of others, and a complex interaction of attitudes, emotions, memories, and experiences, both conscious and unconscious (Glanze et. al., 1990).

Subclinical eating disorder - known as an “eating disorder not otherwise specified”; criteria for AN and BN are not specifically met (i.e., weight still within a normal range despite a significant loss, bingeing and compensatory mechanisms occur less frequently than the criteria describe) (American Psychiatric Association, 1994).

Need - a discrepancy or gap between “what is,” or the present state of affairs in regard to the group and situation of interest, and “what should be,” or a desired state of affairs

(Witkin & Altschuld, 1995).

Needs assessment - a systematic set of procedures undertaken for the purpose of setting priorities and making decisions about program or organizational improvement and allocation of resources. The priorities are based on identified needs (Witkin & Altschuld, 1995). It involves identification of the group affected by the set of conditions in question, and description of how the discrepancies affect them.

Resource - For the purposes of this study, a resource may include any type of information or treatment that is specific to or including males with AN or BN. For example, resources might include pamphlets, books, posters, support groups, treatment programs, and educational approaches.

Availability - For the purposes of this study, availability refers to sources (organizations and health professionals) of information and resources geared specifically to male eating disorder issues; also, accessibility of services (e.g., ease of referral, cost, location, convenience of use, discussion through current treatment program).

1.10 Summary

Both AN and BN can be considered significant health problems for the adolescent and adult male populations. The specific needs of males with eating disorders leads to the need to identify the current availability of educational and support resources for males with AN and BN. The importance of resources is supported by eating disorders organizations and literature on specific programs. Ethical considerations of informed consent, right to privacy, protection from harm, and confidentiality will be considered at every stage of the research process.

Chapter 2 - Review of the Literature

The literature search for this research was conducted through databases related to a variety of disciplines - Medline, PsychLIT, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Sociofile, Sport Discus, HealthSTAR, and ERIC. Some literature and information was also received through government documentation and internet searches.

2.1 General Characteristics of Males with Eating Disorders

The assessment of an eating disorder in males should consider the evaluation of family, behavioral, educational, and psychological factors that may contribute to the development of an eating disorder (Svec, 1987). Both AN and BN exist on a continuum of eating disturbances rather than separate and unrelated illnesses. Individuals may make transitions between food restriction and bingeing in response to hunger. Males may go through many stages of restriction and use of various methods of purging (Kearney-Cooke & Steichen-Asch, 1990). Males with eating disorders may have had dietary problems as children, seen parental marital problems, and have had a close family member pass away (Sharp, Clark, Duncan, Blackwood, & Shapiro, 1994). As well, they may have experienced histories of obesity, sexual identity crisis, and dysfunctional family influences (Farrow, 1992), and have been teased as teenagers, preferred less for athletic teams, and had closer relationships with their mother than their father (Kearney-Cooke & Steichen-Asch, 1990). There may also be a history of childhood physical and sexual abuse (Olivardia, Pope, Mangweth, & Hudson, 1995).

Eating disorders often serve as a distancing mechanism that are unconscious defences against an underlying fear of rejection (Ziesat & Ferguson, 1984). Men who have eating

disorders are avoidant, dependent, and passive-aggressive. Their dependent personalities indicate that they need social approval and deny independent thoughts. Adolescent boys typically learn that being a man involves living by a certain set of values, which include independence, competitiveness, toughness, aggressiveness, and courage. These characteristics can lead to emotional isolation (Kearney-Cooke & Steichen-Asch, 1990).

High anxiety and low self-esteem correlate with abnormal eating concerns (Fisher, Pastore, Schneider, Pegler, & Napolitano, 1994). Males who fear they are over-eating may experience lower self esteem and higher depression than those with no eating concerns; males with under-eating concerns also experience low self esteem (Mueller, Field, Yando, Harding, Gonzalez, Lasko, & Bendell, 1995). A high rate of mood disorders and depression may occur in males with diagnosed eating disorders. Depression does not seem to be a reaction to the eating disorder and is most likely a pre-disposing factor, as it could occur much before one year prior to the onset of the eating disorder (Olivardia et. al., 1995). Psychological vulnerability is a risk factor for development of an eating disorder; an individual that is preoccupied with dissatisfaction over body appearance will, in time, lead to the body becoming the focus of all emotional conflicts (Margo, 1987). Eating disorders serve to curb conflicts that may be common to all adolescents, such as coping with body changes and social pressures (Burns & Crisp, 1985).

Important questions related to eating disorders are: What differentiates those who develop an eating disorder from those who do not? Is the difference based solely on the eating pattern, or are the clinical cases the ones who experience difficulty functioning in other areas of life? (Lachenmeyer & Muni-Brander, 1988). Significant life events may act as precipitants to development of an eating disorder; underlying causes of disturbed eating must be sought elsewhere within the person (Margo, 1987). Is there a way to get at these underlying causes? Research suggests looking at the impact that particular life events have

had on an individual. Poor overall outcome with respect to eating disorders treatment may be related to the success in life that men experience. For example, men who are unemployed for a prolonged period and have developed an eating disorder may be indicating that the eating disorder is a way for them to gain control over their life when they are not happy (Burns & Crisp, 1984).

2.2 Adolescent and Adult Males with AN

A study of 24 cases of males with AN identified mean age of onset as 18.6 years (Sharp et. al., 1994). Other onset ages reported in the literature include 15.5 years (Vandereycken & VandenBroucke, 1984), 16.2 years (Fichter & Daser, 1987), 16.7 years (Hall, Delahunt, & Ellis, 1985), 18.6 years (Herzog, Norman, Gordon, & PePOSE, 1984), 19.3 years (Carlat, Camargo, & Herzog, 1997), 15.5 years (Mangweth, Pope, Hudson, Olivardia, Kinzl, & Biebl, 1997), and 21.6 years (Burns & Crisp, 1984). The oldest age of onset for AN in an adult male found was 53 years (Riemann, McNally, & Meier, 1993). Generally, AN appears in the late adolescent years.

Fichter, Daser, and Postpichil (1985) describe anorexic syndromes in the male as existing on a continuum of three classifications of AN. Primary AN includes refusal to eat accompanied with a morbid fear of fatness. Atypical AN includes swallowing disturbances, depression, neuroses, self-punishment, and medical conditions that lead to food refusal. Secondary AN includes loss of appetite, weight loss, and refusal to eat, but lacks some “typical” features of AN, including denial of illness and weight phobia. In all cases, males experience severe preoccupation with food, weight, and calories, as well as a high level of hyperactivity, achievement orientation, sexual anxiety, over-valued physical fitness and bodily appearance, and obsessiveness (Fichter, Daser, & Postpichil, 1985; Fichter & Daser, 1987).

A substantial decrease in weight magnifies contributing personality features of males

with AN, including preoccupation with food and eating, and discomfort in social interactions (Andersen, 1984). Males with AN may experience depressed mood and obsession, and may be withdrawn in peer relationships (Sharp et. al., 1994). Adult males may experience hopelessness, lack of motivation, personal inadequacy, lack of autonomy and occupational achievement, continued dependence on family, sexual timidity, and increased occupational and social demands of the adult role, leading to the onset of AN as a way to establish control over their lives (Kiecolt-Glaser & Dixon, 1984). Most males with AN see themselves as responding to the needs of others over their own needs. The eventual need for self reliance as an adult seems to conflict with a childhood of extreme obedience (Barry & Lippman, 1987).

Weight related behaviors that are practised by males with eating disorders may include restricted eating, excessive exercise, episodes of bulimia, use of appetite suppressants, self-induced vomiting, and abuse of laxatives or diuretic pills (Touyz, Kopec-Schrader, & Beaumont, 1993). Significant relationships of factors associated with poor outcome in males with AN include long duration of illness, low minimum weight during illness, lack of interest in sports, previous treatment for an eating disorder, disturbed childhood parental relationships, childhood characteristics of shyness and compliance, and absence of pre-morbid sexual fantasy and activity (Burns & Crisp, 1984, 1985). Some males may express relief at the decrease in sexual interest during the intense phases of AN (Burns & Crisp, 1984), indicating that difficult feelings surrounding sexual activity may contribute to vulnerability to eating problems. After clinical treatment, males may continue to be excessively preoccupied with diet and physique (Oyebode, Boodhoo, & Schapira, 1988). It may be that men require additional factors on top of societal pressure to lead to the development of an eating disorder, such as physical complications and serious psychiatric illness; such factors may make the men more resistant to treatment than women (Woodside & Kaplan, 1994). Overall, the outcome pattern for both men and women with AN is very

similar (Burns & Crisp, 1985). A variety of medical complications have been reported in males with AN. Tachycardia, initial cardio-pulmonary arrest, cardiac complications, electrolyte disturbance, anemia, and hypothermia were reported in a sample of male adolescents (Siegel, Hardoff, Golden, & Shenker, 1995).

2.3 Adolescent and Adult Males with BN

In a study of 25 college men with diagnosed eating disorders, 17 had bulimia with an identified mean age of onset of 13.4 years (Olivardia et. al., 1995). Other ages of onset reported in the literature include 18-26 years (Carlat & Camargo, 1991), 15-21 years (Robinson & Holden, 1986), 19 years (Mitchell & Goff, 1984), 19.8 years (Schneider & Agras, 1987), 20.7 years (Herzog et. al., 1984), 19.3 years (Carlat, Camargo, & Herzog, 1997), 17.7 years (Mangweth et. al., 1997), and 25.8 years (range 13-54) (Pope, Hudson, & Jonas, 1986). In a study of Canadian community samples, the prevalence of full-syndrome BN was 1.1% for females and 0.1% for males between the ages of 15-65 years (Garfinkel, Lin, Goering, Spegg, Goldbloom, Kennedy, Kaplan, & Woodside, 1995).

BN in males is often initiated through involvement in competitive athletic training (Mitchell & Goff, 1984). Pre-bulimic men experience a severe pre-occupation with weight control and body image (Gwirtsman, Roy-Byrne, Lerner, & Yager, 1984). Depression, drive for thinness, ineffectiveness, and body dissatisfaction correlate with predisposing factors for BN. Males with BN have a fear of over-eating and an inability to determine satiety, and dissatisfaction with their weight relates to chronic low self esteem. As well, feelings of worthlessness, inadequacy, and insecurity may exist (Ussery & Prentice-Dunn, 1992). Anxieties about obtaining social approval from parents and significant others are associated with the development of BN in males (Gwirtsman et. al., 1984). Men tend to binge as a way to disengage themselves from stressful thoughts or events (Ussery & Prentice-Dunn, 1992). BN is often used as a coping method, indicated by an inverse relationship between symptoms

of disordered eating and stress tolerance (Leal, Weise, & Dodd, 1995).

Outcome of BN in males is affected by their compliance with treatment related to long standing social problems (Mitchell & Goff, 1984). There is a relationship between BN in males and development of major affective disorders, such as depression. This, coupled with the common occurrence of sexual inactivity in males with BN, may indicate prescription of antidepressant treatment to restore active sexual function and remission of BN (Pope, Hudson, & Jonas, 1986).

2.4 Body Image Concerns of Men

Body image disturbance consists of two factors: body image distortion (disturbance of the internal perception of one's body) and body dissatisfaction (disturbance of the feelings about one's body) (Loosemore & Moriarty, 1990). Satisfaction with body image and body weight is not an intrinsic male characteristic, as is commonly thought (Drewnowski & Yee, 1987). The "ideal" body shape for men as portrayed by the media and societal pressures is lean, toned, and thin, with broad shoulders and a trim waistline, also referred to as the "V-shape". Males who have body image problems may be ashamed of their "gut" or "belly", and may have obscured weight perceptions (Kearney-Cooke & Steichen-Asch, 1990).

Drewnowski and Yee (1987) found that 52.6% of normal weight men (n=80) expressed a desire to lose weight to improve their body image and achieve thinness. Men were split, however, between wanting to gain weight (because they perceived themselves as too thin and wanted to be more muscular) and wanting to lose weight. Low waist-to-hip ratio (small waist, large hips) results in increased body dissatisfaction in men because it is seen as an effeminate shape (Joiner, Schmidt, & Singh, 1994). In a study of 25 college men with a diagnosed eating disorder, 80% of them felt moderately or extremely fat at their present emaciated weight (Olivardia et. al., 1995).

Dolan, Birtchnell, & Lacey (1987) exploring body image distortion in men and

women without eating disorders, showed that men overestimate their waist width more than any other body dimension. Overall body width (chest, waist, hips) was overestimated to the same degree as by women, and men most disliked their “beer gut”, chest, waist, feet, or height. The more that the weight of the men deviated from the mean population weight, the more distorted their body estimations were. Fisher et. al. (1994) looked at the eating attitudes of 281 urban males (compared to urban and suburban females). Their relation to perceived weight showed that 18% of urban males perceived themselves as underweight, while 19% perceived themselves as overweight; however, 56% of the sample were within a normal weight range for height (according to height and weight tables). Satisfaction with weight and body pride seems to be equally distributed among middle and low socioeconomic classes, and slightly higher in the high socioeconomic class among both male and female adolescents (Story, French, Resnick, & Blum, 1995).

Body dissatisfaction may be related to stature. Men who are shorter than the average male of the same age may have increased drive for thinness and dissatisfaction with their body, which is also correlated with Body Mass Index (BMI). Males with short stature tend to be more dissatisfied with their weight, and therefore may look to control their weight to improve their body image (Gupta, Schork, & Dhaliwal, 1993). Males with short stature are at risk of becoming preoccupied by size and deviation from an “ideal” physique; this may lead to psychological conflicts and low self esteem focussed on the body. This is a risk factor for developing eating disorders, especially AN, because control over a man’s body becomes confused with control over other issues in their life (Margo, 1987).

A study of body fat distribution and psychosocial variables looked at the difference between men and women. Self-esteem for men was found to be affected by age, income, upper body size and shape, and waist circumference for men. Greater dissatisfaction with their body and lower satisfaction with life were found to be inversely associated with upper

body size in men. The study suggested that weight may be more important in body satisfaction in men, whereas shape plays a more important role in women (Hoffman & Brownell, 1997). Men with eating disorders have been shown to be less likely to be satisfied with their bodies than men without eating disorders (Mangweth et. al., 1997).

For both men and women, poor body image is related to low self-assessments of physical attractiveness, self-acceptance, social self-confidence, popularity with the opposite sex, assertiveness, athletic ability, and self-understanding. However, the relationship between body image and eating behavior may not be as strong in men as in women. This may suggest an indirect link between sociocultural values and eating problems - a man's self-image is based more on ability and accomplishment, whereas women must invest in their physical appearance to attain a sense of well-being and self-esteem (Hesse-Biber, Clayton-Matthews, & Downey, 1987).

Body image affects younger male children as well as adolescents and adults. In a study of Australian school children (8-12 years; mean 10 years), 28% of boys said they wanted to be thinner, and 14% said that they have actively tried to lose weight. This same study also showed that significantly more males than females reported bingeing, and significantly more third-grade children than older children reported bingeing and vomiting. Of the boys who had tried bingeing, 24% had tried to lose weight and 33% had wanted to be thinner. As well, 8% of boys were above the threshold for eating disorders screening (Rolland, Farnill, & Griffiths, 1997). Another study of fourth-grade children (8-12 years; mean 9 years) showed that 2.9% of males were highly concerned about their weight, and all of them wanted to be thinner (Thompson, Corwin, & Sargent, 1997).

Men may be affected over the long term by body image dissatisfaction. A 10-year longitudinal study showed that 10 years after college, men reported weighing more, wanting to lose more weight, and were more likely to be on a diet. The men also showed a moderate

increase in drive for thinness and perfectionism, and a decrease in maturity fears. Many men went from being non-dieters to being dieters. Dieting behavior, body dissatisfaction, and bulimia were significantly related. Lower body weight and increased desires to be thin were predictors of increased weight gain; this means that the men who gained weight were more concerned about being thin than the men who did not gain weight over a 10 year period (Heatherton, Mahamedi, Streipe, Field, & Keel, 1997).

There may be issues concerning gender relationships. As women become physically stronger through athletics, and the role of women changes in society, men may perceive this as “male backlash” as they can no longer assess their masculinity by comparing themselves to women (Kearney-Cooke & Steichen-Asch, 1990). Men themselves may resort to altering their body weight and shape as a way to “fight back”.

2.5 Males, Dieting Behavior, and Weight Control

Desire for weight change in males is not related to the frequency of dieting. Men who have an increased drive for thinness and who wished to lose weight tended to exercise more than to diet (Drewnowski & Yee, 1987). Over-exercising as opposed to dieting may be a more socially acceptable way for men to lose weight (Sharp et. al., 1994). In terms of weight control methods, males may have less of a history of but greater success with diet plans. For choice of weight control, males may choose laxatives, diuretics, diet pills, and other purging aids, the same methods often chosen by women (Schneider & Agras, 1987). Dieting may be less frequent in males compared to females as it carries two different implications: for women, it moves them closer to the ideal body, whereas in men, it moves them further from the mesomorphic ideal (Carlat & Camargo, 1991).

In a health behavior survey measuring the relationship to frequency of dieting to psychosocial and health behavior correlates (n=16,258 males) (French, Story, Downes, Resnick, & Blum, 1995), 187 men reported being frequent dieters (having gone on a diet

more than 10 times), and 171 reported always being on a diet. Of these dieting men, 67 reported purging behavior as a weight loss mechanism. Both diet frequency and purging status were independently associated with increased psychosocial and health behavior risk factors - for example, dieting in men may be inversely associated with family connectedness and positively associated with peer acceptance concerns, emotional stress, family stress, and delinquent behaviors. Increased frequency of dieting was positively associated with increased body dissatisfaction for both purgers and non-purgers. Health behaviors such as binge eating, fear of being unable to stop eating, and history of physical and sexual abuse also increased with frequency of dieting. Adolescent males with eating disorders exhibit greater body dissatisfaction, greater perfectionism, greater restraint, poorer self-worth, and less emotional expression than adolescent boys without eating disorders (Keel, Klump, Leon, & Fulkerson, 1998).

Adolescent males may engage in “defensive dieting” to avoid weight gain after an athletic injury (Farrow, 1992). Men who do diet tend to do so to change body shape rather than specifically to lose weight. Substance abuse (e.g. steroids) may be one way males attempt to either lose weight or change muscle definition. A history of obesity in combination with a sensitive personality may be reasons for men to diet. Dieting in men may be related to sports activities to improve performance (Andersen, 1992).

In relation to physical activity, physically “fit” males have positive attitudes towards the fitness aspect of body image, but are more internally oriented and have more positive attitudes towards the health dimension of body image (Adame & Johnson, 1989). Positive attitudes, then, may be one factor contributing to the lower incidence of dieting in men.

Male dieters may engage in a variety of high risk behaviors (i.e., drug and tobacco use) in an effort to establish connection with and gain approval from peers. As well, dieting may be a way for them to decrease negative feelings directed at themselves (French et. al.,

1995). Sports participation may be more strongly related to eating disorders symptoms than are specific food preferences or dislikes (French, Perry, Leon, & Fulkerson, 1994). Wanting to lose weight has been related to poorer body images for both men and women; the more a person wants to lose, the worse their body image. However, the effect of wanting to lose weight on body image was shown to be less for men than for women (Hesse-Biber, Clayton-Matthews, & Downey, 1987).

2.6 Body Image, Eating Disorders, and Athletics

There are two main hypotheses for the occurrence of eating disorders among athletes. Competitive sports may attract people who tend to have unstable psychological histories or who already practice unhealthy dieting behavior. Conversely, the sport itself may induce these behaviors in otherwise satisfied people by emphasizing weight loss for improved performance (Thiel, Gottfried, & Hesse, 1993).

Body image perceptions may be different in male athletes compared to male non-athletes in that non-athletes demonstrate a linear relationship between body image and percent body fat. Athletes may have a more positive body image because it is related to their athletic accomplishments rather than physical attributes. Athletes may have good feelings about themselves in having made the team and in receiving positive reinforcement from spectators (Huddy, Nieman, & Johnson, 1993). For athletes, their body is a source of honour and a vehicle to achieve value (Andersen, 1992). Despite the positive effect of reinforcement on body image, athletes have an increased overall awareness of their body and its limitations, which may make them susceptible to having low self-esteem. As well, the clothing worn in many sports accentuates and reveals body shape, drawing further attention to appearance (Lindeman, 1994).

In training for a specific event, it may be difficult to distinguish between an extremely committed athlete (who has a strict dietary regimen and intense training) and one who is

suffering from an eating disorder. The mere physical obsession of athletes does not automatically mean the presence of an eating disorder. Psychopathological eating behaviors and distorted body image must also be present (Andersen, 1992). "Obligatory running" is referring to "running addiction" - athletes who are obligatory runners go through "withdrawal" symptoms - such as depression, tension, anger, and sense of body deterioration - when they cannot run for a particular reason. The rigid, ritualistic concern with body weight and control is similar to that described in individuals with eating disorders. Dietary restriction and caloric deficit contributes to rigidity and obsessive preoccupation with exercise, putting athletes at increased risk for developing an eating disorder (Yates, Shisslak, Allender, Crago, & Leehey, 1992).

Thiel et. al. (1993) reported that within their sample of 84 male varsity athletes, 8% of rowers and 16% of wrestlers showed behaviors that fit with an eating disorders profile; 52% practised bingeing. Causal factors for the relationship between sport and eating behaviors risk include sense of ineffectiveness, social isolation, high perfectionism, and fatigue. A study of 131 male lightweight football players (DePalma, Koszewski, Case, Barile, DePalma, & Oliaro, 1993) showed that self-reported weight of the team members was lower than their actual weight. Pathogenic eating behaviors including vomiting (17%), fasting (26%), and laxative abuse (7.8%) were evident. Many of the subjects "felt comfortable" with bingeing behaviors, and fasting was found to occur concurrently with over-exercising. Cycles of bingeing and purging occurred relative to weekly "weigh-in" sessions. The main source of pressure was identified as feedback from the coach or teacher. Subjects also reported that their preoccupation with "making weight" interfered with their work, thoughts, and relationships. This is evidence that "subclinical eating disorders" (early symptoms of eating disorders that have not yet developed into a fully diagnosable case) are prevalent among male varsity athletes. When a normal physical activity is taken to the extreme under conditions of

dietary restriction, then these athletes may be on the road to developing an eating disorder (Andersen, 1992).

Weight training may have a significant effect on the self-concept of males. In a group of randomly selected college males, those who were involved in a weight training course experienced significant improvements in self-satisfaction and personal feelings about self; however, perceptions of self in relation to kin and friends or their perception of moral-ethical self were not affected (Tucker, 1982). Another study by Tucker (1987) of 241 university males showed that males who began weight training at a weaker status gained more in body satisfaction than those who already perceived themselves as strong. Weight training significantly improves body concept because of cultural preference and the view that muscular males are more skillful, strong, and capable. Constant positive feedback surrounding weight training enhances the self-regard of athletes and weight lifters (Tucker, 1982, 1987). The need to increase workload to match the body's increasing strength and seeing physiques change as a result of their own efforts contributes to enhanced self-concept (Tucker, 1982). However, weight training is not a guarantee to improved self-concept and body satisfaction.

“Reverse anorexia” (RA) is a condition that occurs in young men who lift weights. It is characterized by a fear of being too small and of actually seeing themselves as small and weak even though they are of normal size or more muscular. This condition is thought to be a risk factor for the development of full blown eating disorders and abuse of anabolic steroids among adolescent and adult males. Both RA and AN may be related types of body image disturbance or “body dysmorphic disorder.” Cultural expectations and sociocultural factors at a particular time may determine if body builders will be susceptible to developing an eating disorder and their tendency towards RA or AN (Pope, Katz, & Hudson, 1993). Body dissatisfaction may be a risk factor for the use of steroids to increase muscle bulk. In a study

of 134 weight lifters (Brower, Blow, & Hill, 1994), 26% were thinking about using steroids, 37% were current users, and 37% were non-users. Of the high-risk group of steroid users, 38.1% still felt that they were not “big enough,” suggesting that the use of steroids may be in response to body dissatisfaction.

Nutritional behaviors for weight loss and weight gain may be motivated by body dissatisfaction related to sports activity. Taub and Benson (1992) conducted a study comparing 54 adolescent male swimmers with 31 adolescent female swimmers. Among the male swimmers, 63.5% expressed a desire to lose weight and 26.9% expressed a desire to gain weight for competition. Of those who desired to lose weight, 20% were already underweight. A total of 11.1% of the male swimmers were on a diet to lose weight. In relation to eating disordered behavior, the male swimmers also achieved scores at or above those for diagnosed anorexia on the following items: drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, emotional awareness, and maturity fears.

In a study of 45 competitive male body builders (Andersen, Barlett, Morgan, & Brownell, 1995), weight loss methods used in training for a competition included smaller meals (68%), counting calories (56%), special diets (18%), fasting (12%), sauna/steam baths (9%), and drinking less fluid (9%). Weight gain methods included amino acids (50%), extra meals (40%), protein powder (32%), liquid supplements (26%), special diets (11%), decreasing exercise (11%), and weight gain pills (5%). Out of control eating was reported at 2 weeks (3%), one week (10%), and the day of the competition (5%). Sources of nutrition information in preparation for the event included friends (27%), health club staff (18%), magazines (16%), and books (7%). Male racing jockeys may also be at risk for practising unhealthy weight control behaviors. King and Mezey (1987) showed that in a sample of 10 male jockeys, all practised strenuous exercise and used a sauna for weight control purposes.

Others methods employed included dietary restriction (90%), fasting (30%), sweat suits (80%), laxatives (70%), diuretics (60%), appetite suppressants (20%), vomiting (10%), and bingeing (60%). Jockeys may be at risk of developing an eating disorder due to the severe weight restrictions placed on them for competition.

Other studies on male body builders have been done. Loosemore and Moriarty (1990) reported that body builders distort their body image more than a comparison sample of hockey players and non-athletes, who did not differ. Another study found that male body builders perceived themselves to be 15% thinner than they actually were. Women typically feel 15% fatter than they actually are. Thus, this may signal a mirror image of body distortion between male body builders and women who are preoccupied with their weight (Loosemore, Mable, Galgan, Balance, & Moriarty, 1989).

In a study comparing male and female lightweight and heavyweight rowers (Sykora, Grilo, Wilfley, & Brownell, 1993), male rowers reported greater weight fluctuations in-season and greater weight gain off-season than female rowers, and lightweight males reported greater weight fluctuations than all other rowers. Adolescent ice skaters also show nutritional patterns that may not be adequate to support competitive athletic activity. In a study comparing 23 female and 17 male ice skaters (Rucinski, 1989), the male athletes had intakes of vitamin D and folacin that were less than the RDA; their overall energy intake met the RDA but may not have been adequate to support strenuous physical activity. The growth needs of adolescence combined with the nutritional demands of competitive sports puts adolescent athletes at particular nutritional risk. Enns, Drewnowski, and Grinkler (1987) compared the eating attitudes of varsity swimmers, cross country skiers, and wrestlers. The wrestlers had the lowest food intake of all the groups; their estimated caloric intake at the end of the season was well below the recommended level for young adult males. All groups underestimated the fat content and overestimated the protein content of some foods. Thus,

athletes may restrict their diets and lose weight without having adequate nutritional knowledge.

2.7 Comparing Males and Females with Eating Disorders

The key difference between genders with respect to the expression and progression of AN and BN may be related to the actual behaviors surrounding diet and exercise rather than just dissatisfaction with body weight. Women diet much more frequently than men, and describe a greater difference between current and desired body weight. Their desire for thinness is directly correlated with frequency of dieting (Drewnowski & Yee, 1987).

Body image satisfaction may vary by gender. Adolescent males may have a higher level of body image satisfaction than females. Late-maturing girls and early-maturing boys have higher levels of body satisfaction (Cok, 1990). Personal and social cues as to what is considered overweight, underweight, and normal weight may differ for males and females, which is the result of different acceptable weight thresholds for the sexes (Schneider & Agras, 1987). Females describe a greater discrepancy between their actual and desired weight than males (Dolan, Birtchnell, & Lacey, 1987). Pre-bulimic men are more likely to be overweight than pre-bulimic women; as well, men have a higher weight threshold for initiation of purging than women (Carlat & Camargo, 1991). When looking at concerns about body image and weight, male anorexic patients may be quite similar to anorexia female patients where they have an intense fear of weight gain. However, male bulimic patients may be more overweight before the illness than female bulimic patients, suggesting that bulimic males may be less concerned with strict weight control than female bulimics (Carlat, Camargo, & Herzog, 1997).

Of those individuals with eating disorders, women tend to use laxatives more frequently, and exhibit less depression and obsessive moods than men (Sharp et. al., 1994). Females tend to binge in private, whereas males tend to binge at meal time (Ussery &

Prentice-Dunn, 1992). Stature and drive for thinness/body dissatisfaction are not inversely correlated in women as they appear to be in men (Gupta et. al., 1993). As well, males have a higher probability of a past history of obesity, lower probability of childhood sexual abuse, and have more difficulty in the area of sexual and gender identity prior to developing an eating disorder than women. Weight has fewer sexual implications in males than in females (Barry & Lippman, 1987). Personal and social cues as to what is considered overweight, underweight, and normal weight may result in weight thresholds that differ for men and women (Schneider & Agras, 1987). Males with BN may exhibit greater weight fluctuations over time than females with BN, suggesting less rigid and compulsive attitudes towards their diet and weight control programs (Schneider & Agras, 1987). Both males and females with a pattern for developing an eating disorder are more prone to eat when stimulated by external cues than internal cues, suggesting a loss of the ability to recognize internal hunger and satiety (Lundholm & Anderson, 1986). Overactivity in males with AN occurs more frequently than in females with AN (Margo, 1987). Overall, however, there is no evidence that either gender needs more or less severe risk factors to develop eating disorders (Andersen, 1992).

Similarities exist with respect to predisposing factors to eating disorder development between men and women. Both genders belong to subgroups emphasizing change in body weight (e.g., athletes, aesthetic professions). Members of both genders who have an eating disorder are likely to have come from a family with a history of affective disorders, and may have personal histories of mood and personality disorders as well. Both males and females carry with them the possibility that the eating disorder will actually become their identity (Andersen, 1992). Many similarities exist between men and women with regard to the effects of AN and BN on their bodies. Both males and females experience a weight loss of 15% or more below a healthy weight. Both genders experience abnormal hormone

functioning, low blood pressure, slow pulse, decreased muscle mass, non-existent fat stores, and a “bony” appearance as a result of severe dietary restriction. Purging leads to gastrointestinal distress, low body potassium, cardiac arrhythmias, seizures, kidney damage, and general weakness. The main difference in terms of biological changes that occur is that females experience amenorrhea, which is not biologically possible in males (Russell, 1975; in Andersen, 1992). Both males and females continue to experience body distress after treatment for eating disorders (Woodside & Kaplan, 1994).

Similarities with respect to the frequency of dieting and its effect on health behaviors and psychosocial correlates exist between men and women. For both, the fear of not being able to stop eating may be as much as seven times more prevalent in frequent dieters compared with those who have never dieted. As well, for both men and women, diet frequency is most strongly related to poor body image, fears of being unable to control eating, and a previous history of binge eating; also, purging status is positively and independently associated with increased health risk (French et. al., 1995).

Personality characteristics of men and women may give clues to the underlying emotions of an eating disorder. Males with eating disorders may tend to be more obsessional, anti-social, and manipulative; females with eating disorders present as more hysterical and immature (Vandereycken & VandenBroucke, 1984). Both men and women with AN exhibit similar personality characteristics of nervousness, aggressiveness, depression, irritability, dominance, inhibition, openness, intraversion, and emotional lability. Women exhibit lower sociability (Fichter, Daser, & Postpichil, 1985). Anorectic males self-rate sexual anxieties, somatic complaints, extroversion, sociability, and femininity higher than anorectic females on the same items (Fichter & Daser, 1987).

Eating behaviors may be affected by levels of stress. In a study comparing intake response to stress, males reported stressful situations to include school work, romantic

relationships, and money. For females, they included these same similarities with the addition of family. Men and women did not differ with respect to increasing food intake during periods of stress. The authors did note, however, that associations between intake during severe stress and some eating behavior variables are substantially different between men and women, and that the two genders need to be looked at in different ways (Weinstein, Shide, & Rolls, 1997).

In a study of the relationship between tolerance for stress and symptoms of bulimia (Leal, Weise, & Dodd, 1995), males reported significantly higher tolerance for stress. However, men at risk for an eating disorder may be average in emotional stability and overall adjustment, but have difficulty performing well in high stress situations. Women, on the other hand, may be at risk for developing an eating disorder due to low self-confidence in approaching new situations and handling unknown challenges. For both, an inverse relationship between tolerance for stress and symptoms of disordered eating indicates BN as a coping method. A study comparing 102 male and 91 female undergraduate university students showed that females had higher scores for cognitive restraint, disinhibition, drive for thinness, body dissatisfaction, interoceptive awareness, bulimia, and ineffectiveness. Males, on the other hand, showed higher scores for maturity fears (Lundholm & Anderson, 1986). As well, females may have greater difficulty in recognizing emotions and hunger than males. Women may be more likely to report a dislike of a particular body part (hips, breasts) than men, who report dislike with more general features (height, overall bulk) (Dolan, Birtchnell, & Lacey, 1987).

With respect to body image, men and women may differ in their body image evaluations. Relative to men, women report more negative feelings towards their body image, stronger self-focus on appearance, and more frequent body image distortion. Women had greater discrepancies between actual and ideal overall appearance, muscle tone, skin

complexion, facial features, weight, and physical strength (Muth & Cash, 1997). Similarly, a study of pre-adolescent school children showed that females selected a smaller “ideal” body size than the males did. However, over time, the females tended towards selecting larger body sizes (decreasing dissatisfaction and moving closer to their actual weight), whereas the males did not. That males chose “ideal” body sizes smaller than their actual size contrasts the generalized concept that females are more dissatisfied with their bodies than males (Sands, Tricker, Sherman, Armatas, & Maschette, 1997).

2.8 Relationship of AN and BN to Homosexuality

The estimated prevalence of homosexuality among the general male population is between 6-10% (Carlat & Camargo, 1991). There has been some research exploring a postulated relationship between the incidence of eating disorders in males and homosexuality. One theory is that there may be greater importance placed on appearance in the “gay subculture”, and therefore greater chance of body dissatisfaction (Silberstein, Mishkind, Striegel-Moore, Timko, & Rodin, 1989). A study that compared body satisfaction of heterosexual and homosexual men discovered that homosexual men rated attractiveness as their primary motivation for exercise, whereas heterosexual men rated fitness, health, and enjoyment as their primary motivations. As well, homosexual men rated physical appearance significantly more important to their sense of self than physical activity, whereas the reverse was true for heterosexual men (Silberstein et. al., 1989). Herzog, Newman, and Warshaw (1991) also found that heterosexual men tended to be more satisfied with their bodies than homosexual men, although this finding was not statistically significant.

Body satisfaction and feelings of attractiveness in homosexual men may be related to the degree of discrepancy between perceived current figure and “ideal” figure, which may be higher among homosexual men (Silberstein et. al., 1989). In a comparison study of 32 heterosexual and 43 homosexual men, 15.4% of the homosexual men thought they were

overweight despite being actually at a normal weight; only 7.7% of the heterosexual men thought the same (both not statistically significant). As well, 21% of the homosexual men chose an ideal weight that was below their recommended weight for height, whereas none of the heterosexual men did; the overall choice for ideal weight among homosexual men was 3.9% below that recommended (both statistically significant) (Herzog, Newman, & Warshaw, 1991). This raises the question of whether there is a difference between homosexual and heterosexual men regarding what they consider to be an “ideal” male body. Silberstein et. al. (1989) reported that only 14.1% of gay men and 16.9% of heterosexual men thought their current weight matched their “ideal” body size. Homosexual men may consider an attractive male figure to be much slimmer than the perceived “ideal” of heterosexual men. As well, what homosexual men consider attractive to a potential partner is based on what their own “ideal” shape is, meaning that their concern with appearance may be largely related to their desire to fit with the opinions of others (Herzog, Newman, & Warshaw, 1991).

The relationship of these weight and body shape issues and eating disordered behavior among homosexual men is of concern. In a study of 13 male anorexic patients and 14 bulimic patients (Herzog et. al., 1984), the males with eating disorders (compared to a heterosexual control group of eating disordered women) were more likely to have had no sexual relations and to report being homosexual (26% frequency), and were significantly less likely to be currently involved in an active heterosexual relationship. Homosexual men may be more likely to report past or present problems with binge eating, diuretic use to control weight, being terrified of being fat, and feeling fat despite others perceptions (Yager, Kurtzman, Landsverk, & Weismeier, 1988). However, Yager et. al. (1988) reported no significant difference between homosexual men and a group of male athletes (n=48 and n=110 respectively) in the incidence of self-induced vomiting, laxative use, excessive deliberate weight loss, and overactivity without enjoyment. However, it was not known if

there were any homosexuals in the control group of athletes. Silberstein et. al. (1989) reported no significant difference between homosexual and heterosexual men in the incidence of dieting, self-control around food, and bulimia. However, among the gay men, those who chose a thinner “ideal” figure had higher scores on the dieting scale associated with attitudes and behaviors associated with disregulated eating. Mangweth et. al. (1997) found the association between homosexuality and eating disorders weak as the majority of their males described themselves as heterosexual.

Overall, it may be that homosexual men fear weight gain to a greater extent than do heterosexual men because they perceive that a weight increase would make them less attractive to a potential partner (Herzog, Newman, & Warshaw, 1991). The subcultural emphasis on appearance may make body dissatisfaction more culturally normative for gay men than for the general male population (Silberstein et. al., 1989). More generally, among some homosexual male college students, behaviors and attitudes related to eating disorders are those that would be expected if these homosexual men were at greater risk for developing an eating disorder (Yager et. al., 1988). The reluctance of men to seek help for a stereotypically female problem may be compounded by embarrassment to acknowledge sexual conflict; these issues together may contribute to the lower reported incidence of eating disorders among males in general (Herzog et. al., 1984). Homosexuality may be a psychological stressor for adolescent males, and cases of early onset BN, for example, may show a higher incidence of homosexuality because homosexual males develop BN closer to puberty than heterosexual males (Carlat & Camargo, 1991).

In summary, homosexual men can be considered a risk group for the development of eating disorders. Also, homosexual and gender identity issues are noted in male eating disordered patients (Braun, 1997). Homosexuality is just one risk factor for developing an eating disorder; not all males with an eating disorder are homosexual.

2.9 Factors Affecting Incidence and Identification of Eating Disorders in Males: Low Prevalence or Low Identification?

Eating disorders among males may be under-diagnosed; many males and health professionals assume that eating disorders occur only in adolescent females (Andersen & Mickalide, 1983). The lower incidence of males with eating disorders may partially be an indication of their greater hesitation to seek treatment compared to females (Mitchell & Goff, 1984; Carlat & Camargo, 1991). It may be for reasons of social approval and competitiveness that males are less likely to seek treatment (Olivardia et. al., 1995), for fear that they will ruin their “perfect” image in the eyes of others. Males with bulimia, for example, may be hesitant or embarrassed to discuss the disorder or may deny the problem. In a group of 15 males with bulimia, they expressed embarrassment about attending a clinic for the eating disorder, were unstable in keeping appointments, and tended to drop out of treatment (Schneider & Agras, 1987). Anorexic or bulimic males may be generally more resistant towards professional help or less likely to seek treatment than female patients (Fichter & Daser, 1987).

The incidence and prevalence of eating disorders among males may be considered low because males are less exposed than females to social and environmental influences that lead to physical effects on the body - i.e., media pressure for thinness (Steiger, 1989). Emphasis on muscle development rather than slimness, later entry into adolescence than females, and propensity to “act out” rather than “internalize” psychological issues may contribute to lower reported incidence of eating disorders in males (Kiecott-Glaser & Dixon, 1984). The terms used by males to describe their body and/or motives for weight loss may be different than those used by females, making the underlying reasons for body dissatisfaction less evident - e.g., weight loss for “muscle definition” compared to “slimness” (Andersen, 1984). Males have higher thresholds for defining a binge and are less ready to

admit to over-concern with weight and shape (Braun, 1997). Less intense social and advertising pressure on males to be slim may, in part, account for the lower incidence of eating disorders among males (Andersen & Mickalide, 1983; Barry & Lippman, 1987).

In a study comparing Austrian men with eating disorders to American men with eating disorders, only two out of 25 American men had seen a psychologist for their eating disorder, and none had seen a psychiatrist (all Austrian men had seen one or the other) (Mangweth et. al., 1997). Touyz, Kopec-Schrader, and Beaumont (1993) report that there is often a long delay before being referred to an eating disorders specialist. The reasons for this delay may include males' resistance to treatment and a lesser degree of awareness among professionals about eating disorders in men. The diagnosis of an eating disorder in adolescent or adult males may be hindered by a doctor's search for medical compared to psychological explanations for symptoms (Andersen, 1984). Males may not meet some of the attitudinal criteria for diagnosing an eating disorder, such as experiencing a negative effect after a binge, and therefore might not be identified (Lachenmeyer & Muni-Brander, 1988). As well, clinicians may find it difficult to diagnose eating disorders in males because presentation of the disorder may have features, such as somatic complaints (e.g., hypothermia, hypotension, constipation, ankle edema) that camouflage the central psychopathologic symptoms of an eating disorder (Andersen & Mickalide, 1983). Clinical diagnosis of an eating disorder may be difficult as males do not experience a DSM-IV symptom analogous to amenorrhea in women (Herzog et. al., 1984).

Health care professionals familiar with female eating disorders may not consider the possible diagnosis of AN or BN in a male because the symptoms, personality characteristics, and weight history may be different than their female patients (Schneider & Agras, 1987). Physicians need to consider the possibility of the diagnosis of an eating disorder in teenage boys with significant weight loss (Romeo, 1994). For these reasons, there may be more

males with AN than are known who are seeking medical attention for other related physical problems but who have not been diagnosed with an eating disorder (Romeo, 1994). Relying simply on observations of female patients with eating disorders, whether in research or in professional practice, further isolates male patients who are already isolated due to their minority in the population of individuals with eating disorders (Vandereycken & Van den Broucke, 1984). Helping males to feel more comfortable and educating professionals were two suggested ways to encourage men to request treatment and resources for their eating disorder. "It is unhelpful and demeaning to treat male anorectic patients as if they were teenage girls" (Andersen & Mickalide, 1983, p.1073).

2.10 Approaches to Addressing Eating Disorders in Males

The way that an eating disorder is addressed may determine what types of treatment and educational resources are used with eating disorder clients. Various resources may be consulted depending on the focus and purpose of treatment or education, and what aspect of AN or BN is being examined. Eating disorders in males may be addressed both from a preventive and treatment point of view. Preventive approaches to addressing eating disorders include educational programs, written information, and awareness; they address the issues that contribute to an eating disorder and how to counteract them before an eating disorder begins. Treatment approaches include individual and group counseling, hospitalization, and support groups.

Eating disorders prevention and treatment needs to focus on improvement of interpersonal skills, self-concept, organizational skills, and conflict resolution skills; enhancing expressiveness; communication skills, including attention, following, and reflecting; improved self-awareness coupled with assertiveness, which may lead to self-disclosure and personal independence (Felker & Stivers, 1994). Parental support of self-directed behavior and decision making of male adolescents is a crucial part of growth and

development. Communicating love and acceptance regardless of weight and appearance will improve self esteem and sense of worth (Romeo, 1994).

Prevention programs were described as needing to focus on a wider spectrum of eating disturbances - focusing on moderate conditions may prevent the consequences from becoming long-term. Primary prevention needs to focus on AN, BN, and obesity to avoid excess focus on one condition (decreasing obesity) at the expense of others (increasing unhealthy dieting behaviors). Programs should aim to increase adolescents' understanding of sociocultural and individual factors that contribute to body image disturbance. As well, they should promote increased understanding of healthy eating and exercise, consequences of dieting and eating disorders, and understanding the multi-causality of disordered eating. Prevention programs may include informal messages encouraging healthy relationships and acceptance of a wide range of body sizes, gender equality, autonomy, critical thinking, social skills, and empowerment. Options range from one time lectures to integration of eating disorders prevention into the curriculum of schools (Neumark-Sztainer, 1996). It is indicated that prevention programs need to focus on recognizing problem eating behavior among children as well (Childress, Brewerton, Hodges, & Harrell, 1993). Information about the negative consequences needs to be supplemented with other issues of focus including nutrition, healthy body image, and sport performance (with athletes) (Lindeman, 1994).

Prevention strategies in athletes need to focus on secondary intervention to shorten the duration of the illness and prevent development of full blown eating disorders; primary intervention is limited because of lack of control over individual predisposing factors that contribute to developing an eating disorder. Prevention must be aimed at de-emphasizing the importance of weight, avoiding the use of group weigh-ins, and eliminating unhealthy "subculture" of rapid weight loss through dieting, dehydration, and starvation (Lindeman, 1994).

Other aspects of addressing eating disorders through health promotion may be related to the source of knowledge about AN and BN. In a study by Murray, Touyz, & Beaumont (1990), an assessment of community knowledge about eating disorders was conducted. The greatest sources of knowledge for the 65 women surveyed were books/magazines (68%) and TV (46%), whereas for the 64 men surveyed it was TV (61%), books/magazines (46%), and knowing someone with an eating disorder (25%). Other areas less mentioned included knowing of a friend or relative who had AN or BN, general conversation, and school/university. When discussing prevention, it must be considered whether exposure to information about eating disorders actually affects the attitudes towards dieting and other related issues of the target group. Here, 39% of women and 13% of men with knowledge of either AN or BN indicated that their attitudes and eating habits were affected by their knowledge of eating disorders, including making them more cautious of both their own and others' eating behaviors.

In the same study by Murray, Touyz, & Beaumont (1990), of those with knowledge about AN (99% of women and 97% of men), the most commonly mentioned behaviors related to AN were starving, overdieting, becoming very thin, distorted body image, psychological consequences, vomiting, and being life threatening. Of those with knowledge about BN (70% of women and 16% of men), the most common behavior that was predominantly mentioned was induced vomiting. In fact, 57% of all respondents with knowledge about BN mentioned only bingeing and/or vomiting as characteristics of BN. Interestingly, with respect to AN, only 5% of the women (n=3) and 6% of the men (n=4) with knowledge about AN checked off that they believe that sufferers of AN are female. With respect to BN, 4% of women (n=2) and 0% of men (n=0) with knowledge about BN checked off that they believe that sufferers of BN are female (Murray, Touyz, & Beaumont, 1990).

Interventions to address eating disorders in athletes must take into account negative

feelings about body image, inappropriate dieting behavior, and goals and expectations for themselves. Nutritional intervention and assessment for this group depends on sports performance, readiness to talk and learn about nutrition, and their nutritional status (diet and weight history, body fat and its role in performance) (Lindeman, 1994). Sports personnel, including coaches, administration, trainers, and parents can address eating disorders through understanding and management, communication of the importance of proper nutrition for performance, being acutely aware of the dieting and eating behaviors of their athletes, and raising consciousness about the risks of eating disorders to overall health (Lindeman, 1994).

Treatment for eating disorders in males must begin with building an alliance between health professionals and the individual of concern. Weight restoration is important; however, this must occur with therapy and the patient's belief that they will not become obese when they resume normal eating patterns. Free expression of feelings, rights, and desires as part of psychotherapy is crucial. Family therapy may aid in alleviating anxieties and evaluating family interactions which may be a source of stress (Barry & Lippman, 1987). There should be a focus on coping with stress, fears, confusion, feelings of helplessness and ineffectiveness, and low self esteem (Lindeman, 1994). Having the male with AN participate in previously avoided activities (e.g., social interactions) may be a method of boosting self-confidence and sense of ability (Kiecolt-Glaser & Dixon, 1984). The therapist and the patient need to share the same goals for treatment. Therapeutic strategies that focus on gaining control over eating compared to simply gaining weight give the individual a greater sense of control over his own success. Emphasis on positive reinforcement for progress can be a source of encouragement. As well, assertiveness training may help improve difficulties that an individual experiences in interacting with other people (Ziesat & Ferguson, 1984).

In a study of day hospital treatment for males with eating disorders, it was found that male patients were able to be treated in a group therapy setting where the majority of the

participants were female. The presence of males changed the content (topics discussed) of some of the groups, but they were issues that would not surface had there been all females in the group, and the change was not thought to be adverse (Woodside & Kaplan, 1994). Some males have indicated dissatisfaction in being the only male involved with the group being treated for anorexia. As well, men may want to speak with a current or former member of the group before making the decision to join (Andersen & Mickalide, 1983).

Riley (1991) has compared 12-step programs with alcohol and eating disorders. These programs are based on an addictions model and consist of group meetings, fellowship and sponsorship, and looking at the addiction as a disease. Individuals work through a series “steps” which help individuals recognize themselves as having an addiction and assist them in feeling more comfortable with themselves and not using the behavior to alter mood. The 12 steps are completed sequentially and include admitting powerlessness over the addiction, restoring a relationship with God, and making amends to people who have been hurt by the individual. Similar to alcoholism, AN and BN can be out of control and dangerous or life threatening if it is not stopped. Groups who follow the 12-step model can provide ongoing sources of support to individuals and decrease feelings of isolation through the use of sponsorship and assisting the individual by encouraging others to help. The 12-step model may be helpful in working with goals of eating disorders treatment, such as gaining control over eating patterns, effecting cognitive changes, and establishing and maintaining goals. The 12-step model may also provide support and depression when integrated into an overall treatment program for eating disorders.

The role of the eating disorders treatment team is both of educator and counselor. The team approach can be used in both inpatient and outpatient settings (Landau-West, Kohl, & Paskula, 1993). A consultation service for eating disorders has been recommended to assist professionals with eating disorders patients. Drawing on other professionals for

consultation may assist referring doctors in making accurate diagnoses and recommending appropriate treatments. Prompt consultation is urgent where early diagnosis and treatment of AN and BN leads to improved outcome (Andersen & Mickalide, 1985). This may be particularly significant for male patients displaying disordered eating behaviors.

2.11 Issues in Eating Disorders Resource Use

Resources for addressing a number of issues related to eating disorders in males or females may exist in a number of forms. Written materials, such as pamphlets and fact sheets, may provide information on eating disorders and encourage those afflicted to seek help. Books and manuals, whether of a self-help or academic nature, can provide description of eating disorders and inspirational stories. Self-help and therapy groups are used in both clinical and informal settings for both patients and concerned friends and family of those suffering from eating disorders; they may be facilitated by health professionals or others recovering from an eating disorder. With the rapid growth of computer and on-line information, the existence of chat lines and links to eating disorders organizations may also act as resources for anyone affected in a variety of ways by both AN and BN. Websites may offer general and specific information on eating disorders, links to organizations, and self-help resources.

The success of an eating disorders education program may be dependent on a number of factors. In a program at Stanford University, the format involved highlighting the personal stories of students who had undergone treatment for AN or BN, but this program backfired. The program seemed to encourage the very behaviors it was trying to prevent. The presentation of “recovered” eating disordered patients brought mixed feelings - their appearance of being in control over their lives and looking very thin and “healthy” downplayed the serious physical and emotional consequences that eating disorders bring (The Washington Post, Fitness, 1997).

Conventional therapy (i.e., the traditional medical model) is not always the most successful method of addressing the underlying factors that contribute to an eating disorder (Managed, 1993). Programs may fail because they concentrate on the physical symptoms rather than the emotional risk factors and consequences. Some individuals may imitate the physical symptoms described in eating disorders education to achieve exactly what they are being warned against; some information may actually be providing “helpful hints” on becoming very thin (The Washington Post, Fitness, 1997). Short term hospital stays often serve to suppress a patient’s symptoms while glossing over the underlying issues. Often, upon release from hospital, many patients return to their eating disordered behaviors because they have not learned to cope with their emotions and/or events in their lives (Managed, 1993).

Self-help groups have some particular benefits in addressing the needs of both males and females with eating disorders. The group takes away feelings of isolation felt by sufferers and helps dispell health myths; also, members serve as role models for each other. A family support group may provide information about resources, sharing of experiences and coping methods, reinforcing trust in the family’s judgement, and building of an extra-familial support system (Kinoy, 1985). When considering the composition of a self-help support group, mixing gender or having a group composed of all men may have an effect on the dynamics of the group and the willingness of the men to “open up” in a particular environment. This must be considered when suggesting this type of support resource to males who have AN or BN.

Although the actual abundance of internet resources for eating disorders appears extremely helpful, such as chat lines, web sites, and FAQs (centres for frequently asked questions), there must be a note of caution. Many people find it helpful to seek support and connect with other people who are experiencing many of the same issues. However, not all

internet sites are monitored by health professionals, and as a result, much of the information being made available may be inaccurate or unhelpful. As well, individuals should not rely solely on on-line resources as they are often impersonal and must be judged with serious discretion (Van Dine, 1996).

The use of resources in addressing the needs of individuals suffering from AN or BN must be assessed on an individual basis. With respect to the specific needs of males with eating disorders, the success of the use of any type of resource is not well known or established.

2.12 Summary

Research on males and eating disorders raises several issues related to eating behaviors and characteristics of the individual. Understanding the various aspects of eating disorders in males is relevant in discussing resource needs of this group. The general characteristics of males with eating disorders, including pre-disposing factors and personality correlates, suggest the issues that need to be addressed. Dieting and other behaviors associated with AN and BN reinforce the effect that eating disorders have on men's lives. Body image concerns of men include an "ideal" V-shape and severe body image distortion related to low self-esteem, stature, self-acceptance, and perfectionism. Weight loss behaviors of men include dieting, excessive exercise, purging, and substance abuse. Athletes may be particularly affected by eating disorders. Males involved in weight related sports, such as wrestling and bodybuilding, may be susceptible to body image and weight pressures. "Reverse anorexia" in bodybuilders and body image distortion in a variety of athletes may lead to unhealthy dieting and purging behaviors. Males and females are similar in many aspects of eating disorders, including risk factors, body image distortion, use of purging aids, psychological factors, and physical effects. The main differences between men and women with AN and BN include frequency of food restriction and desired body image. The

relationship of homosexuality to eating disorders in males has not been established - body image pressures among the gay population focus on thinness and appearance; however, there is no evidence that only gay males develop eating disorders. It is uncertain if the incidence of eating disorders among males is actually as low as reported or if eating disorders are not identified as readily in men as in women. Eating disorders resources may include written information and treatment strategies, and may focus on body image, disordered eating behaviors, pre-disposing factors, and issues specific to client needs. The use of resources for males with eating disorders has not been researched extensively.

Chapter 3 - Methodology

3.1 Qualitative Design

3.1.1 Paradigm Rationale and Assumptions

This research project is a Qualitative Inquiry through conducting an Interview Study. Schlesinger (1996) used a similar model for her study. Lincoln and Guba (1985) state two prime directives of naturalistic inquiry:

“... no manipulation on the part of the inquirer is implied, and ... the inquirer imposes no a priori units on the outcome” (p.8).

The real meaning of the inquiry is set in the context of the lives of those being studied (Lincoln & Guba, 1985). The “human-as-instrument” ideology behind naturalistic research is based in characteristics of responsiveness, adaptability, holistic emphasis, knowledge base expansion, immediate processing of data (on the spot), and opportunity for clarification, summarization, and exploration of atypical responses (Guba & Lincoln, 1981).

“The naturalistic investigator cannot confine his or her attention to a few variables of interest, ignoring the setting because it has been so carefully controlled; he or she must take account of all factors and influences in that context” (Lincoln & Guba, 1985, p.191).

Tacit knowledge is gained from experience with people; good research is not only the study of outcomes, but of the process as well (Lincoln & Guba, 1985). Lincoln and Guba (1985) state four main elements of qualitative research:

- 1) purposive sampling - selecting a sample with the purpose of the research in mind, to include as much information as possible about the context of the research.
- 2) inductive analysis of data - using multiple sources of knowledge to uncover “hidden” meaning and information; unitizing and categorizing of data occurs, with

no a priori theory defining outcome.

3) development of theory - expressing theory from the knowledge gained rather than a priori theory guiding data collection and analysis; units of data emerge because of the investigator's perception of their importance rather than because of a pre-imposed theory.

4) emergent design - developing the study as it progresses based on the meaning of context, multiple realities, and unpredictable interaction between investigator and context; continuous data analysis and developing relationship between the investigator and the participants contribute.

“Objective reality can never be captured” (Denzin & Lincoln, 1994, p.2). Reality is, in effect, the meaning in context, affected by both the researcher and the researched. There are multiple and often conflicting constructions of reality, and all are meaningful. The “truth value” of qualitative research is in the consideration of all realities, of the best-informed research (Schwandt, 1994). Criteria of authenticity are employed; educative authenticity, which refers to the improved understanding of constructions of others, and catalytic authenticity, which refers to direction for action resulting from the research (Guba & Lincoln, 1994). Appendix B presents an overview of Qualitative and Quantitative Paradigm Assumptions.

3.1.2 Needs Assessment Methodology

“A needs assessment is not intended to provide diagnostic information about individuals. Its purpose is to make decisions regarding priorities for program or system improvement ... If the needs assessment is well done ... it should lead to measures that will directly benefit the individual with the needs” (Witkin & Altschuld, 1995, p.5).

The context of a needs assessment is one of a “cyclical relationship”; the identification of a need and evaluation of a program in meeting that need leads to a new phase of assessment and planning for re-direction of resources. It is not a top-down activity;

rather, it seeks to involve service recipients and providers in providing information and having an integral part in the decision making process in setting needs and priorities (Witkin & Altschuld, 1995). These are the thoughts that underline the focus of this study and decision to use needs assessment methodology; we cannot make changes and recommendations without knowing what will make the greatest practical difference. Those who are affected will be able to provide first hand insight on the problem at hand, identifying their “real” needs as opposed to what they are told they need.

The focus of this study was not on individual actions - e.g., what purging behaviors the males engage in as a result of their eating disorder, or what traumatic life events may have lead to its development. Rather, the focus was on the resources and programs available, what the males would like to see in their current environment, issues that need to be and should have been addressed at the beginning of their illness, and educational and support resources they need that may or may not be currently available.

In reporting the findings of a needs assessment, three errors can be made: not documenting the findings, not reporting the findings in useful formats, and not providing the information to relevant people (Soriano, 1995). In the case of the current study, every effort has been made to avoid these errors. The information yielded was documented not according to individual or group interviews, but by emergent themes identifying areas lacking attention in the area of educational and support resources for males with eating disorders as identified by health professionals and male patients. The format of the findings will be constructed so as to reflect specific issues that need to be addressed in developing new resources, along with suggestions for use of the information. The findings will be reported to prominent health professionals and organizations, both on a provincial and national level, for consideration in the direction of eating disorders education.

3.1.3 Interviewing as Knowledge Inquiry

Interviewing is interaction, and interaction is the greatest way to study the human being. It can be used to understand individual or group perspectives, and can be one time or multiple exchanges of information (Fontana & Frey, 1994). The current study used semi-structured individual and group interviews as a method of knowledge inquiry and interaction with participants. Participants' lives need to be addressed in their own terms (Edwards, 1993). The interview format allowed the participants to express their “voice”; the language, feelings, and experiences that are conveyed become the essence of the research. It acts as an stimulus toward collaboration and building constructive and comforting relationships (Hargreaves, 1996).

The purposes for doing an interview include obtaining “here and now” constructions of personal environment, reconstructions of experiences, projections of those experiences and their effect on the future, verification of knowledge obtained from other sources (triangulation), and extension of constructions to practice (member checking) (Lincoln & Guba, 1985). Interviewing is an important means of capturing the target group's point of view, and the meaning that participants' give to their own experiences (Denzin & Lincoln, 1994). Qualitative interviews have a flexible design; early questions are open ended and more general, with subsequent questions focusing more on specific issues (Rubin & Rubin, 1995). Interviews are a key method for data collection in conducting a needs assessment; key informants can identify specific areas to explore and factors that contribute to the need (Witkin & Altschuld, 1995).

3.1.4 Interviewer Skills

In the current study, the researcher has played an “intercalary role”. Described by Fielding (1993), this role incorporates compatibility between the values of the researcher and the participants to the extent that information and knowledge can be gained, taking the

participant's beliefs and values seriously. The success of this role depends on the extent to which the participants can be made to seem “real” to the external audience. Participants must be empowered and able to identify with the goals of the research (Bowser & Sieber, 1993). The view of the participants towards the research and the researcher will affect their responses and behavior (Edwards, 1993).

Social characteristics allow the researcher and the participants to “place” each other and therefore have bearing on the relationship between them. Age, sex, socioeconomic status, and perceived social/organizational status may all have an effect (Edwards, 1993). The main issue of concern in the current study is the difference in gender between the researcher (female) and the target group (male). Female researchers may be caught in a stereotypical gender role designated by subjects, especially in male dominated groups. It is important to understand the issue of sensitivity from the participants' point of view; establishing collaborative research with participants and building trust will remove communication barriers (Renzetti & Lee, 1993).

There are several methodological issues facing the researcher in conducting interviews. The researcher should feel comfortable in his/her role as the interviewer; preparation is necessary to address emotional responses and dynamics of conversation (Ayella, 1993). A natural environment must be created. The interviewee needs to perceive conversational competence, understanding of the issue, and connection with the group through recognition and empathy. As suggested by Rubin and Rubin (1995), main questions should direct the discussion; probes, such as body language and brief phrases, should be used to signal interviewees to continue, and follow-up questions should be used to explore the implications of what the participants say and pursue themes that are discovered. It is important to portray the perspective of the participants to represent the “reality of the group”. In maintaining communication with the group, it is important to be forthright about the goals

of the research, avoid interviews that seem highly partisan or superficial, and show that the researcher is sensitive to how the information revealed might be put to use by others (Ayella, 1993). As well, new issues may arise during the interview, and the researcher must be prepared to incorporate them into the study (Rubin & Rubin, 1995).

3.1.5 Triangulation of Data

Lincoln and Guba (1985) propose a technique of “triangulation” as a method of establishing trustworthiness in qualitative research. This approach involves the use of multiple sources of information as well as numerous methods of data collection, investigators, and theories guiding the research. Data triangulation has been used for this study, which simply refers to the use of several data sources of information. Methodological triangulation was applicable here in considering the use of both interview data and resource documentation (Lincoln & Guba, 1985). Janesick (1994) proposes interdisciplinary triangulation, which strengthens qualitative research by drawing on a variety of disciplines to broaden our understanding of method and substance. Here, the fields of education, psychology, psychiatry, nutrition, and branches of medicine all enriched the knowledge base. Mathison (1988) refers to triangulation as obligating the researcher to be explicit as much as possible about the research process, providing a rich and multi-faceted picture of the issue being studied.

3.2 The Researcher's Story

My background in the field of nutrition and dietetics includes an undergraduate degree from St. Francis Xavier University in Antigonish, Nova Scotia (1994) in Nutrition and Consumer Studies. Currently I am pursuing a Master of Science degree in community nutrition. I am a student member of the Dietitians of Canada, and am involved in their professional network on eating disorders. I am a member of the Saskatoon Interagency Committee on Eating Disorders, which is a professional coalition that serves to provide

information and education surrounding eating disorders. I have had practical experience in the field of eating disorders as a volunteer for the Anorexia and Bulimia Society in Kingston, Ontario (1995) which serves to run a phone line for information and support. Since the fall of 1996, I have read books on eating disorders by Anderson (1990), Brownell, Rodin, and Wilmore (1992), and Krasnow (1997), as well as a great deal of research on eating disorders in general as well as specific to males.

From a personal perspective, I believe that no one is immune to the pressures of achievement and perfection, and no one can avoid societal views of beauty and attractiveness. I have never had an eating disorder, but I have hated the way my body looked and felt pressure to change it. My choice to investigate the needs of males with anorexia and bulimia arises from my realization of their situation in terms of being under-researched, receiving little attention as a group with a legitimate health concern. As well, even with what we know statistically about this group, there is little knowledge of the feelings and thoughts the men themselves have about their health concerns. To me, the best and most thorough information comes directly from those who are affected.

My biases arise in my empathy to how the target group must feel isolated in seeing that the majority of resources surrounding eating disorders are addressed to women. I believe that even a group who represents a minority of those affected by a particular health issue deserves consideration and respect on the part of health professionals and researchers, as well as national health organizations. One of my thoughts is that the incidence of males with eating disorders is actually higher than reported, as they are reluctant to come forward and seek help due to being embarrassed or fearing that they will not be taken seriously. I have the perspective that the current support services and eating disorder resources are inappropriate for dealing with the special needs of males. These judgements may have influenced the way that I have understood and interpreted the data. Nonetheless, every effort was made to

acknowledge these opinions and be open-minded during the collection and analysis of information. Methods of verification to ensure validity and reliability were used to ensure the credibility of the research reported.

I want to discuss some of the challenges of being the researcher for this sensitive topic. Primarily, it was important to set my boundaries as a researcher. Although the intent of questioning was to discuss treatment and information resources, there was always the chance that personal stories would come out during the interviews, as well as some emotional and sensitive information. During the interviews with the male eating disorder participants, a number of very serious and distressing issues indeed arose (not directly related to the research questions but more to their personal experiences with the eating disorder). It was important to define my role as a researcher but not as a counselor or therapist at the outset of the interviews - I am not a trained counselor, nor am I qualified to treat eating disorders. My position was always that I am limited in the therapeutic help I can offer, but I would be willing to listen to their stories should they voluntarily decide to offer them. The participants were told that the interview questions would not be about their personal experiences that lead them to an eating disorder, and should any questions be asked that made them uncomfortable they could refuse with no pressure from the researcher.

I was grateful to hear their stories and experiences. It enriched my understanding of their struggle and their perception of resource need. I was comfortable in the role of listener and being able to act as a “tool” to express their perceptions and opinions. I encouraged them to share and expand where they were comfortable; by assuring them that I was respectful of their experiences, that the interviews were absolutely confidential, and that the goals of the research were to make practical recommendations to address eating disorders, it encouraged them to open up and talk. For the health professional participants, the same assurances were made, which encouraged them to open up about their professional experiences and feelings

on the issue.

Renzetti and Lee (1993) note that the sensitivity of the research is not the topic itself but the context in which it occurs. Some of the issues that I prepared myself for were related to the sensitivity of discussing experiences with an eating disorder. What if a participant experienced an emotional episode during an interview? What if issues came up that were a danger to their health (e.g., suicide, abuse)? What services should I be prepared to refer them to and how would I handle the situation? I prepared by finding out about services for various issues that were available in the city. Should I be presented with a situation during an interview that required referral to a service, I would be prepared to offer suggestions (only if they did not already have a counselor or were in treatment). There were a number of very sensitive and difficult issues that came up during interviews; some of them included suicidal tendencies, past emotional and physical abuse, past substance abuse, and very disturbed family dynamics. As a researcher, it was very difficult to hear these stories - I handled it by writing in my reflexive journal and stepping away from the research to regain my objectivity and clear my mind for the next interviews so that the distress would not affect my abilities as an interviewer and researcher.

When dealing with people as data collection “instruments”, it is difficult to end the research. I struggled with how to give them and myself closure to the research. For the male eating disorder participants, I provided the feedback report and a final “thank you” note as tangible closure. For myself, closure begins with the acceptance of this thesis; even so, it is distressing to not have regular contact with them or the health professionals. As you become part of their lives and their work, ending the research is like letting a part of your life go.

Frustrations of the research included scheduling interviews, cancellations and delays, failure of audio equipment, difficulty contacting participants, interview transcription, and computer breakdown (and consequential losing of some completed writing).

3.3 Research Design and Data Collection Procedures

3.3.1 Description of Target Group

There were two main target groups for this study - health professionals who work with eating disorders, and males with AN or BN. Members of both of these groups were interviewed. Both groups were the main source of information that contributed to this research. As well, both groups were considered key stakeholders for the results of this study - information about the availability and use of treatment and information resources for males with eating disorders may provide practical information for both professional and personal use.

3.3.1.1 Criteria for Participation

There were specific criteria for participation for the health professional participants. Criteria included that the participant worked with eating disorders patients, either adolescent or adult. They may have been from any professional field related to addressing eating disorders. Their work may have been in either education or treatment, as well as involvement with support groups. That they have worked with male patients was an asset but not a necessity; experience with any eating disorders patients was considered to contribute valuable insight to the issues surrounding body image and self esteem as related to eating behaviors.

There were also specific criteria for participation for the male eating disorder participants. Criteria included that they had been identified by a health professional (at some time during their illness) as having AN or BN. Originally, one of the criteria was that they needed to be referred to the study by a health professional. However, as the study continued, there were a number of males that came to the attention of the researcher through other avenues. These men were included if they had been identified by a health professional as having an eating disorder (even though they were not referred to the study by that health

professional).

3.3.2 Needs Assessment Design

Witkin & Altschuld (1995) propose a three phase needs assessment structure. Phase 1 is the Pre-Assessment phase, Phase 2 the Assessment phase, and Phase 3 the Post-Assessment phase. This research study incorporated the following activities in each of the three phases:

- Phase 1 - Pre-Assessment. The pre-assessment phase for the current study consisted of the preparation of a research proposal, a phase of exploration. The purpose of the needs assessment was specified - the identification of resources for males with AN or BN, and definition of additional resources and programs for support, education, prevention, and recovery. Identification of existing information regarding need areas was conducted through the literature review. Research regarding what is already known about males with AN or BN, indicators of need of this group, and issues related to eating disorders all were considered in evaluating the current situation. Interviews with key informants identified broad areas to explore in depth. Methods and types of data collection were specified (interviews and documentation). Written agreements (i.e., consent forms) specified the roles of both the needs assessment conductor (i.e., the researcher) and the key stakeholders (i.e., study participants). Potential uses of the data were outlined, giving the needs assessment a focus.
- Phase 2 - Assessment. This is the phase of information collection, the actual conducting of the research. Findings on the needs of males with AN or BN were gathered in the areas needing assessment, as defined in the research proposal. Goals of the research were outlined, and the current state of the target group was compared to the desired end result. The interview schedule was set out, and key informants were identified and contacted. Needs occur at three levels:

i) Level 1 - Service recipients. Input from study participants, in this case male eating disorder clients, provided identification of areas that were far from the “what should be” state. Previous attempts to meet the needs, and current barriers that exist in meeting the need were identified.

ii) Level 2 - Service Providers. Characteristics of the current situation and providers of educational and support resources (e.g., health professionals) that might contribute to the maintenance of the need state were explored. For example, lack of knowledge of an issue may contribute to the existence of the need.

iii) Level 3 - Resources. Inadequate system resources, such as lack of funding or research interest, were recognized. Resources may also refer to the educational and support services under search in the current study.

- Phase 3 - Post-Assessment. The prioritization of needs forms the basis of the action plan, which are the recommendations made by the research. This is a phase of utilization, where the findings are put into a format that can be practically used. Recommendations for changes to address the needs are made, reports prepared, and the information disseminated to key individuals who are in a position to effect the recommended changes.

Soriano (1995) also describes several steps that need to be taken in developing a needs assessment. They include: defining the purpose and objectives, specifying roles and responsibilities of involved parties, selecting a target population and subgroups, identifying stakeholders and resources, and using the information. These activities can all be considered as incorporated into the above framework.

3.3.3 Resource Search Design

3.3.3.1 Documentation of Eating Disorders Resources

Current literature and educational and support resources were collected as part of the

identification of available resources specific to males with AN or BN. The following specific issues were explored.

- i) Status of the issue of males with eating disorders. Material relating to provincial and national eating disorders organizations, including organizational mission statements, philosophies, program descriptions, and services offered specifically targeted at males with an eating disorder was documented.
- ii) Availability of support services. Knowledge and availability of support services for male eating disorder patients was described.
- iii) Use of eating disorders resources in health care. Those educational resources that are currently in use by health professionals and organizations for male eating disorder patients were sought. Collection of resources occurred when available.
- iv) Identification of self-help and recovery resources. Non-scientific literature, including biographical books and post-treatment recovery avenues, geared towards males with AN or BN were reported. (This step also occurred with book publishers outside of Canada, as books can be ordered for use in Canada).

3.3.3.2 Resource Search Contacts

Resource identification and documentation involved thoroughly searching Canadian resources through several main venues. Information that was requested included services offered, available resources, attention given to the issue of males with eating disorders, and key individuals and health professional positions in the field of health education and eating disorders. Appendix C provides a copy of the resource description form sent to resource contacts.

- i) National health organizations. Health Canada and the National Eating Disorders Information Centre were contacted both by phone and written correspondence. Through this outlet, identification of national research and resource development occurred.

As well, direction to provincial health organizations and services was achieved.

ii) Provincial health departments. Through addresses and contact information obtained from Health Canada, respective provincial health departments (including the territories) were contacted through phone and written correspondence. Individuals identified included provincial nutritionists, provincial eating disorders coordinators, and other professionals connected to the area of eating disorders on a governmental level. As well, a few hospitals who offer eating disorder clinics and therapy services became known and subsequently contacted.

iii) Internet connections. Web searches of Canadian Health Promotion sites, Canadian Nutrition sites, Canadian Eating Disorder sites, and other health and medicine related locations were explored. On-line support and information sharing groups were identified and contacted via the Internet. Efforts of various research groups were recognized, and some individual private and not-for-profit organizations related to eating disorders were identified.

iv) Private and not-for-profit organizations. Clinics, support groups, and volunteer coalitions who are currently conducting treatment, therapy, and/or research were contacted. They were identified through contacts with other organizations, health professionals, government documentation, and the internet.

v) Snowballing. Any contacts that were made yielded other contacts with groups, individuals, and organizations. Informal discussions with health professionals, fellow graduate students, and eating disorder patients, as well as information that arose during the interviews for this study, provided additional contacts.

Appendix D provides a complete list of organization names and addresses contacted for resource information.

3.3.4 Health Professionals

A list of health professionals (i.e., service providers) in Saskatoon associated with the

identification and treatment of AN and BN was obtained from the Saskatoon Interagency Committee on Eating Disorders. Contact with those associated with organizations outside of Saskatoon were obtained through mail and phone request. The use of lists and networking provided a substantial number of contacts. A cover letter (Appendix E) describing the purpose, structure, and goals of the project was sent to the professionals on the list. As well, this letter requested the voluntary role of the health professional in helping to recruit male eating disorder cases, and assured confidentiality of participation and the information obtained. The letter was followed up by personal contact, either by phone or in person, re-stating the request. Once all responses had been received, further contact was made to outline arrangements for interviews. A cover letter was also sent to a variety of health professionals in Saskatchewan and across Canada (Appendix F); a follow-up phone call identified those who had specific experience with male eating disorder clients.

Health professionals were requested to help recruit male eating disorder patients for inclusion in this study. This had the added benefit of providing the researcher with an idea of the reaction of the male patients to participation in the study. As well, through informal discussions, these professionals suggested topics that might be explored separately with the male eating disorder participants and thereby contributed to the design of those interviews.

The interview guide was developed to focus on information related to the knowledge and use of treatment and educational resources by the health professionals for their eating disorder clients. Appendix G provides a copy of the interview guide used. Questions were designed to invite the health professionals knowledge of the issue of males with eating disorders; this included groups affected and issues to focus on, as well as opinions on what resources would be useful for this group. Discussions with the research supervisor and thesis committee members provided valuable input on the focus of the questions as well as the format (to reduce bias and leading of participants' answers).

Appendices H and I contain copies of the consent forms for the individual and group interviews with health professionals.

3.3.5 Males with AN and/or BN

Contact with these participants was achieved through requests made by health professionals, both in and outside of Saskatoon. Networking and professional contacts aided in recruiting adolescent and adult males with AN or BN. The researcher provided information to health professionals that they then passed on to their male eating disorder clients. The males contacted the researcher themselves if they were interested in participating in the study. The researcher confirmed that they had an eating disorder through conversations with the participants. A total of eight males contacted the researcher, and all were found to be eligible for the study. None were limited or excluded from the study, and none chose to withdraw after the request for an interview had been made. Participant recruitment was considered complete when recurrent themes began to arise during the interviews, and when no additional males had been referred to the study (confirmed through conversations with health professionals who were helping in recruitment).

Before conducting the formal interview, the researcher met with each of the participants informally to discuss the project and answer any questions the participants had. This was done for the purpose of establishing rapport and comfort between the researcher and the participant. During the informal first meeting with the male eating disorder participants, a letter was provided to them outlining the structure and goals of the research, as well as what the role of the males would be. Appendix J provides a copy of that recruitment cover letter. There was no consent form for this initial meeting as it was not an official part of data collection and it was not tape recorded.

Individual interviews were thought to be the most appropriate choice for the initial discussion due to the very sensitive nature of the issue and the need for privacy and

confidentiality. The goals of the individual interviews were to discuss the participants' previous exposure to and use of educational and support resources, as well as how they perceived the current attention given their particular health concerns. In addition, participants were asked to describe other resources needed to facilitate prevention of and recovery from anorexia and bulimia for males. The interview guide was developed to focus on participants' personal experiences with treatment and information resources for eating disorders.

Appendix K provides a copy of the interview guide used. Questions focused on types of resources that participants had used for their eating disorder, what had been suggested to them, what they had found useful, and what additional resources (if any) would be helpful. Discussions with the research supervisor and thesis committee members provided direction for question development and areas of focus. Appendix L contains a copy of the consent form used for the initial interview with the male eating disorder participants.

At the end of the individual interviews, participants were given three options for further participation for feedback purposes: a second individual interview, a group interview, or no additional interview. A letter was sent to the men after the initial discussion explaining the feedback options (Appendix M). After this letter was sent, some participants could not be reached by phone to confirm their feedback preference. A second letter was sent to these participants to request their response regarding feedback (Appendix N). This interview was also semi-structured, using key themes from preliminary analysis to guide the discussion. The interview guide (Appendix O) was developed based on the key, recurrent themes from the interviews with health professionals and the male eating disorder participants. Opinions of both the health professionals and the males were included; each result was read to the participants, and they were asked to offer clarification, additional input, and agreement or disagreement. The purpose was to explore those themes that had come up consistently during all interviews and that would be part of the results of the research. Appendix P provides a

copy of the consent form used for the feedback interviews. A feedback report was also prepared for the male eating disorder participants (Appendix Q).

The issue of the difference in gender between the participants and the researcher was considered. This did not pose any problem in terms of communication between the researcher and the male participants. The establishment of trust and respect of the researcher, along with openness about the research project and its goals, established a comfortable environment for discussion (Ayella, 1993).

3.3.6 Interview Recording Procedures

Both the group interviews and individual interviews were audio taped and then transcribed by the researcher. An assistant was present for the group interviews only; their role was to take notes of the discussion to support transcripts made from the audio tape. They were informed of the importance of confidentiality, and permission was received from the group being interviewed for the assistant to remain present. Only one group interview with health professionals was not tape recorded at the request of one of the participants; the professional felt that it was sufficient to have the assistant take notes of the conversation. Transcripts for this interview were made from notes taken by the assistant. Any thoughts, feelings, or reactions experienced during the interview by the researcher were recorded into the reflexive journal immediately after the discussion so as to consider them in data analysis. As the transcription process is inherently subjective, every effort was made to include pauses, indicators of tone of voice or emotion, sentence connectors (“um”, “ah”), and verbal communications not in the form of words (laughing, emphasis, garbled sound, sighing, etc...) so as to capture as accurately as possible the context of what was said.

As well, brief notes were made during the interviews by the researcher to indicate the context of discussion and emotion of the respondents. This provided an opportunity to note questions that were used in subsequent interviews and to note the need for elaboration or

probing into particular topics. Immediately after both the group and individual interviews, notes and reflections were made by the researcher regarding context, emotions, and non-verbal communications of the participants.

3.3.7 Reflexive Journal

As an additional method of information collection and recording, a chronicle of material relating to both the “method” and the “self” was kept. Lincoln and Guba (1985) call this type of diary a “reflexive journal.” The main purposes of the journal were to provide a record of dynamic thoughts regarding methodological decisions made during the course of the research, as well as to provide insight on the thought processes and reactions of the researcher. A three part format for the journal was as follows:

- 1) the daily schedule and logistics - This included dates and times of interviews with participants, as well as progress of resource documentation. Consultations with the research advisor, thesis committee members, and health professionals and organizations were recorded.

- 2) a personal diary - This provided the researcher an opportunity to record emotions, additional questions, insights, frustrations, biases, perceptions of the research process, and speculations about research findings.

- 3) a methodological log - Any changes or additions to the methodology, along with a rationale, were recorded for continuing consideration during the research process. These included changes to interview format and/or reactions of participants to the interview process.

Entries in the journal were made as necessary - e.g., after interviews, upon reading additional material. Lincoln and Guba (1985) suggest that where it is a subjective activity, the journal may be used to assess how the researcher's own thoughts have influenced the findings, and is an important tool for establishing trustworthiness.

3.4 Data Analysis

“Inductive analysis” of data involves the use of an iterative procedure, a succession of question and answer cycles (Huberman & Miles, 1994). Miles and Huberman (1994) identify 13 tactics for generating meaning from qualitative knowledge. They include:

- noting patterns and themes
- seeing plausibility
- clustering
- making metaphors
- counting “what's there”
- making contrasts/comparisons
- partitioning contributing variables
- comparing data to general categories
- narrowing contributing factors
- noting relations between factors
- finding intervening factors
- tying factors to the literature
- building a logical chain of evidence

The idea is that, as knowledge is gained and information accumulates, there is a constant process of data analysis occurring; themes, recurrent ideas, and patterns of belief are identified and incorporated into the next step of the research as well as into the analysis of findings (Lincoln & Guba, 1985). “Content analysis” refers to the division of data into units of meaning and definition of these units according to certain criteria. The content of the text is to be emphasized, not allowing the bias of the researcher to affect the outcome of results. In general, content analysis applies quantitative methods to textual material - rule formulation, need for deduced categories, and utility of generalizable findings (Rosengren, 1981; in Lincoln & Guba, 1985). Fieldnotes, observations, and any documentation can be continuously employed in data analysis. Information is coded into categories, which may incorporate setting/context, situation definition, participant perspective, process, views of people and objects, activities, events, strategies, and relationships (Bogdan & Biklen, 1992).

The steps taken in data analysis for this research involved identifying emergent themes and categories. The resource search information was analyzed very basically - the

resources gathered or described as available were categorized into “male specific resources” and “non-gender specific or combination resources.” The resource information collected came from the formal search procedure, professional contacts, health professional interviews, the internet and e-mail.

Analysis of the interview transcripts began with the preparation of the feedback report. This report was prepared from the summary reports for each health professional interview and the transcripts of the first set of male eating disorder participant interviews. The content of the report was based on those issues that were discussed most frequently and strongly, consistently among the men and the health professionals. The interview guides were also used as a guide for writing the report. This gave a “draft” list of major categories of information; sub-themes were created in each major category based on issues that came up during the interviews. A process of “unitizing” proceeded. Lincoln and Guba (1985) described this as units of information that will serve as the basis for defining categories. The units should be heuristic (aimed at some understanding or action that the inquirer needs to have or to take) and be the smallest piece of information about something that can stand by itself. The transcripts from all sets of interviews were coded, and participant responses were “cut-and-paste” into the categories and sub-themes which fit the topic they were in response to.

As the analysis continued, a number of themes became evident from the discussions, and they were noted as areas of focus. As relationships between categories emerged, the categories changed - some categories became sub-themes, some became further divided. Some information was placed into more than one category. Information was placed into

categories following specific criteria: if the title of the category appeared in the participant response, if the segment was in response to a particular topic (but did not contain the actual title word), and if the segment was explicitly expressed as a particular topic (e.g., a barrier). These processes are discussed by Lincoln and Guba (1985).

When deciding on focus of results and discussion, the research questions were examined. Since the research questions were specifically related to treatment and information resources, those categories and sub-themes that related to resources received attention. Other categories which were not used directly for the reporting of results were reviewed for supporting information related to resources; they will be reserved for further publishing of other results of the research. These categories included personal stories offered by the males, contributing issues that influenced the development of the participants' eating disorder, professional approaches to treatment of eating disorders, perceptions of groups affected by eating disorders, the physical effects of an eating disorder that participants experienced, and parallels with other health issues that were drawn.

3.5 Methods of Verification

In the tradition of the qualitative paradigm, Lincoln and Guba (1985) describe four methods of verification as “trustworthiness criteria.”

3.5.1 Credibility.

This takes place of “internal validity” in the quantitative paradigm (Denzin & Lincoln, 1994) and includes activities which increase the probability that credible findings will be produced to add to the “truth value” of the research. These activities may include prolonged engagement, persistent observation, and triangulation (Lincoln & Guba, 1985). In

this study, engagement and observation were considered to include extensive communication with all participants, which was continuous for the duration of the study. Triangulation has already been discussed. Peer debriefing (Lincoln & Guba, 1985) occurred continuously during the research. Debriefing with the research supervisor and committee members after individual and group interviews provided the opportunity to explore questions, interview format, interviewing skills, researcher biases, and suggestions for additional topics to explore. Referential adequacy (Lincoln & Guba, 1985) involved the use of audio recordings and transcripts, “raw data” against which to relate data analysis and interpretations. Member checks (Lincoln & Guba, 1985), to confirm responses and input, consisted of the summary reports distributed to health professionals and the feedback reports and interviews with the male eating disorder participants. During the group and individual interviews, any statements that were not clear to the researcher were explored and clarified immediately.

3.5.2 Transferability.

Replacing the concept of “external validity” in quantitative research (Denzin & Lincoln, 1994), transferability refers to the ability for the audience to apply research findings to other contexts and situations (Lincoln & Guba, 1985). “Thick” (detailed) description of the participants, their experience with the issue of male eating disorders, resources identified and their uses, context of conversations/comments, personal characteristics of the interviews, and provision of all issues discovered during the course of the research provided an adequate portrait of the research so that audience members may reach conclusions about its applicability to other situations.

3.5.3 Dependability.

Like “reliability” in quantitative research (Denzin & Lincoln, 1994), dependability refers to the stability of data over time. Changes are considered as much a function of what is being studied as of the process of studying; changes occur in the emergent design as working theories develop. A “dependability audit” is the mechanism of examining the process by which the research was accounted, and examining it for accuracy (Lincoln & Guba, 1985) so that external individuals may also study the process by which the inquiry occurred.

3.5.4 Confirmability.

Parallel to the conventional concept of “objectivity” (Denzin & Lincoln, 1994), confirmability considers whether or not the findings of the study can be legitimated. A “confirmability audit” examines the end product of the study, the findings, and determines their accuracy. The process involves examination of raw records, called the audit trail, in order to determine trustworthiness of the research (Lincoln & Guba, 1985). The use of field notes, memos, and a reflexive journal aid in this process (Denzin, 1994).

Lincoln and Guba (1990) later proposed a revised set of criteria known as “authenticity criteria,” employed for judging the quality of the “product” of the research. Resonance criteria emphasize reliance on pattern theories, rejection of generalizability, and examination of the investigator's role in a self-critical, self-questioning, and self-correcting way. Rhetorical criteria are used to assess the form, structure, and presentational characteristics of the report; unity, logical organization, simplicity, and craftsmanship of the structure of the research are essential. Empowerment criteria refer to the ability of the research to facilitate action on the part of the readers, to provide definite direction for future

goals and not just “directions for further research”; raising the consciousness of the reader and providing arguments that readers can use in their own situations for action. Applicability criteria allow the reader to use the research findings in their own context or situation, through transferability and thick description. These criteria arise from those described earlier by Lincoln and Guba (1985) for judging the quality of the “process” of the research, and will be fulfilled concurrently through similar activities.

3.5.5 Audit

An “external audit” was conducted at the end of the research as a method of strengthening dependability and confirmability (Lincoln & Guba, 1985). The ideal external auditor would be an individual with experience with eating disorders treatment or education and in conducting needs assessments; the auditor was not directly involved with the research. Field notes, documents, data, theoretical notes, journals, research drafts, and all other relevant materials were kept by the researcher and were provided for review and familiarization with the research. The auditor assessed the research in terms of its confirmability, groundedness of findings in the data, logical inferences, utility of categories of findings, dependability, appropriateness of inquiry decisions and methodological shifts, implementation of design, credibility, integration of outcomes, and incidence of inquirer bias throughout the research. The purpose of the audit was to confirm that the research findings were not fabricated or distorted, and that both the product and the process are authentic (Lincoln & Guba, 1985).

Refer to Appendix R for a copy of the audit report confirming the trustworthiness of the study.

3.6 Ethical Approval

An application for approval of research design was submitted to the University of Saskatchewan Advisory Committee on Ethics in Human Experimentation for the Behavioral Sciences. Information submitted included an abstract, description of participants, methods and procedures, discussion of risks for participants, and discussion on confidentiality, consent, debriefing and feedback. As well, a draft of the interview guides and consent forms were included. Confirmation of ethical approval was received on June 30, 1997. Appendix S provides the confirmation of ethics approval form.

3.4 Summary

A qualitative interview study was the vehicle for conducting a needs assessment of resources for males with AN and/or BN. Phases of pre-assessment, assessment, and post-assessment described the environment in which the issue of males with eating disorders is addressed. The interview format provided opportunity for both health professionals and male eating disorder clients to express their thoughts and perceptions of the issue of educational and support resources for this group. The prominence, availability, and use of eating disorders services gave an overview of current resources. Health professionals who work with eating disorders clients provided a practice perspective, whereas the male eating disorders participants explored their personal experiences with resources. The majority of interviews were tape recorded and transcribed; data from a number of sources were compiled and organized into themes to provide implications for the development and use of eating disorders resources for males.

Chapter 4 - Results and Discussion

4.1 Description of Research Participants

4.1.1 Health Professional Participants

A total of 15 health professionals in Saskatoon were interviewed. They consisted of 5 clinical dietitians, 2 private practice dietitians, 1 dietitian/therapist, 1 public health nutritionist, 2 psychiatrists, 2 social workers, and 1 psychiatric nurse. Of these 15 health professionals, nine had current or past experience with male clients having AN or BN.

In addition to these interviews in Saskatoon, there were five telephone interviews conducted with key individuals identified through other contacts. These interviews involved one medical doctor and one psychiatrist from Toronto, and one psychiatrist, one psychiatric nurse, and one clinical dietitian from Saskatchewan.

Interviews with Health Professionals

The health professional participants were interviewed through both group and individual interviews. They were interviewed if they responded to the request of the researcher, indicating an interest in the research study and a willingness to be interviewed. They were offered the choice of participating in a group or individual discussion, and the option was self-determined based on their schedule and comfort with the options. The interviews took place either in a neutral location (for the group interviews) or in the participants' offices. There were two group interviews done - one with three professionals and one with four professionals. There was one two-person interview, and six individual interviews. All interviews were conducted in Saskatoon, and were semi-structured interviews using open-ended questions. All were tape recorded except for one group

interview; one of the health professionals in the group felt that it was sufficient for the assistant to take notes of the conversation. Transcripts of this interview were made from notes taken by an assistant (not quoted from in results; used as supporting information). The group interviews consisted of a range of professionals, some of whom consulted with each other but none of whom worked in the same facility. Results of the group and individual interviews were fed back to the health professionals in the form of summary notes made from the transcripts. This provided opportunity for the health professionals to confirm the information noted and comment further on the issues that emerged. The telephone interviews were not tape recorded. Notes were made by the researcher according to answers given to specific questions. This information will not be quoted from, but used as support information for the main issues of analysis.

Appendix T offers a profile of the health professional participants.

4.1.2 Male Eating Disorder Participants

Communication with the male eating disorder participants was established in a number of ways. As contact was established with the health professionals, business cards from the researcher were given to those professionals who had current or past male eating disorder clients. Where appropriate (as determined by the health professional), the contact information for the researcher was passed on to those males, who then made the decision to contact the researcher. In a couple of cases, the health professional had approached the male, and then passed the male's contact information on to the researcher, who then made the initial contact. This was done with the permission of the male involved. In one case, the man approached the researcher himself upon hearing about the research project. In another case, the male was referred by one of the male eating disorder participants who was a friend, both of whom had diagnosed eating disorders. Overall, the referral sources were as follows: one man from a psychiatrist, one man from a clinical dietitian, four men from social workers,

one man who was self-referred, and one man who was friend-referred.

A total of eight males with AN and/or BN were interviewed during this research. They ranged in age from 18 years to 42 years at the time of the study. Their age of onset for the eating disorder ranged from nine years to 39 years old. Seven out of the eight men had been officially diagnosed or identified with an eating disorder - three men had AN, three men had BN, and one man had AN and BN. The eighth man was identified as “disordered eating” and was thought by his social worker to be pre-anorexic. He was interviewed as someone at the early stages of AN and from the perspective of resources that would help him at this point. (Ages and type of eating disorder were offered voluntarily by each of the men.)

The men varied in their current health status related to the eating disorder. Three men were extremely ill at the time of the research (two with AN and one with AN and BN). Three men were recalling their past experiences with BN; these men did express, however, that they had experienced reoccurrences of the eating disorder since “getting well.” Two men were at an “in-between” stage of the eating disorder, sometimes practicing it often, and sometimes not at all.

The men also varied in treatment status and experience. Two of the men were in current, active psychiatric treatment at the time of the interviews. One of the men had received psychiatric treatment for the eating disorder in the past. One of the men had experienced past counseling, and the eating disorder was addressed in the context of other issues. One of the men had not yet received counseling for the eating disorder, but was in current counseling at the time of the interview for other issues. One of the men had previously received dietetic counseling as a way to address the eating disorder. And two of the men had received no counseling or treatment currently or in the past for their eating disorder.

The men also varied in their experiences contributing to their eating disorder.

Through voluntary sharing of personal stories, contributing factors included family dynamics, athletics, low self-esteem, distorted body image, co-morbid psychiatric disorders, and physical disabilities. Four of the eight men voluntarily identified themselves as homosexual.

All eight men participated in an initial discussion through individual, face-to-face interviews. Interviews were tape recorded. The interviews were conducted in a neutral place where none of the men or the researcher had any personal connections. The people involved with the organization where the interview room was located did not know the topic of the research to avoid linking any of the participants with the issues being explored. Privacy and confidentiality were assured. The interviews were semi-structured using open-ended questions. Participants were encouraged to express all opinions relating to treatment and information resources.

Three of the eight men participated in a second interview for feedback purposes. Seven of the eight men were approached for the second feedback interview, but five of them declined for various reasons. One of the men moved away from the city and was not geographically available for the feedback interview. One of the men had come down with a virus at the time of the feedback interview and was unable to re-schedule. Two of the men declined due to scheduling conflicts and the feeling that a second interview “just wasn’t something (they) could do.” One of the men was not approached for a feedback interview - he had difficulty focusing on the research questions in the initial interview due to his emotional state and insistence on focusing on family problems. The men who participated in the second interviews received the feedback report after the second discussion; the other five men received the feedback report soon after it was compiled and after they declined the second interview.

Appendix U offers a profile of the male eating disorder participants.

4.2 Resource Availability in Canada

Part of understanding resource needs is understanding and knowing about what resources are already available. Appendix D, “List of Organizations Contacted for Resources,” outlines the resource search that was part of this study. The object was to identify resources in Canada that could be used for addressing eating disorder concerns of males. A number of resources were found, both male specific and non-gender specific. Resources were identified by both the organizations contacted and the male participants, as well as the health professionals. Not all resources are “Canadian” by nature - some were developed in the United States but are available in Canada and have been included in resource results for that reason.

4.2.1 Male Specific Resources

Appendix V, “Resources Specific to Males and Disordered Eating,” offers a summary of resources and their bibliographic information identified through national and provincial contacts. These resources are in addition to research literature, which is outlined in the reference section of this thesis. Some of the resources are not specific to anorexia or bulimia but are related to associated concerns and issues - male body image, steroid use, healthy physical activity. Many of these resources are specific to anorexia and/or bulimia.

The first item, “My Life as a Male Anorexic,” is the only existing autobiography of a male suffering from (and surviving!) an eating disorder. The other books are more for educational purposes, describing eating disorders in men, the issues involved, and the research that has been done. For example, “Males with Eating Disorders” is a thorough introduction to the topic of males and eating disorders.

Some of the resources are geared more for professional use. Activity kits, teaching manuals, and promotional materials (pamphlets, posters) are best used in body image and eating disorders education for males. They are less useful for the males themselves as a self-

help resource. The activity kit from the Yukon government is a one-day activity combining workshops/activities on body image, nutrition, personal care, and “what it is to be male,” with rock climbing. “The Steroids and Body Image Project” by the Canadian Centre for Ethics in Sport contains a number of promotional materials that bring awareness to the issue of male body image and it’s relationship with steroid use risk.

Resources such as fact sheets and bulletins are geared for public awareness and support for males with eating disorders. Two bulletins from the National Eating Disorders Information Centre, “Men with Eating Disorders” and “Eating Disorders in Gay Men: Current Issues,” contain facts on eating disorders in males, influencing factors, perceived barriers, and general awareness. The fact sheets, “Adolescent Males and Eating Disorders,” and “Adolescent and Adult Males with Eating Disorders: Some General Facts,”

The support group for gay males with eating disorders was identified through contact with health professionals. It operates on a six-week commitment by members. At the time of the research, the group was in its third week of the first program. It operated on the premise that males like to know that they are not the only one struggling with an eating disorder, and common experiences would foster a sense of comfort and belonging.

The book “Muscle: Confessions of an Unlikely Bodybuilder” was referred to this research as a resource on body image issues in men. A copy could not be obtained for the study, and therefore no further details can be described.

4.2.2 Combination and Non-Gender Specific Resources

Several non-gender specific resources were identified as useful for males with eating disorders. When organizations were contacted and the resource description form sent requesting resources used for males with eating disorders, many organizations responded with non-gender specific resources. Appendix W offers a list of those that were identified through the resource search and interviews. The details of gender specificity of resources

will be discussed in greater detail later. However, many organizations and health professionals identified readily available resources that are useful to both males and females. Again, most of these resources are geared for professional use in education and health promotion. As well, they are not all specific to anorexia or bulimia. Some resources focus on general healthy living (“Vitality Leader’s Kit”), self-image (“Heads Up”), and healthy eating (“The Eating Edge”). They can be considered “combination” resources, where both males and females are represented when talking about eating disorders and body image. “Beyond the Looking Glass” and “Real People with Eating Disorders” are two examples. They may be presented to mixed groups (male and female adolescents) as well as professionals.

Many of the organizations contacted for resources, as well as the health professionals and men with eating disorders, noted counseling agencies, self-help and support groups (local), and treatment programs as combination or non-gender specific. These types of resources, available in most major centres, would need to be assessed on a local basis through specific health professionals for their accessibility and applicability to males with eating disorders.

4.2.3 Beyond the Identified Resources

One of the questions asked of the organizations contacted for resources was “How would people know how to find this (resource)?” Of the organizations that responded, some avenues of promotion were through newsletters, promotional materials for the organization, word of mouth, professionals (doctors, dietitians), and initiating contact with schools and organizations to see if the program fits with their needs.

When organizations did not have any male specific or non-gender specific resources to offer to the research, further contacts were often given. Some contacts were for individual doctors, psychiatrists, and dietitians in the cities where the organizations were located. Their

involvement with eating disorders was with either education or treatment. Thus, there are likely a number of private treatment programs, individual doctors, hospitals, clinics, and groups that may possibly be available for males with eating disorders. This would need to be researched on a local basis.

Several non-profit eating disorders organizations exist, including the Saskatoon Interagency Committee on Eating Disorders and the Kingston Anorexia and Bulimia Society. These groups are often made up of professionals who educate members of the public and distribute eating disorders resources. The Saskatoon Interagency Committee on Eating Disorders accesses Saskatchewan Health for its information. Many non-profit organizations rely on their provincial health departments for resources.

4.2.4 Internet

Several information and treatment resources for males with AN or BN were found on the Internet. Appendix X provides a list of websites that contain information specific to males with eating disorders. The focus of the internet search was on identifying potential treatment and information resources, not evaluating them. Beyond this list, there are many websites that are related to eating disorders in general. They offer general information, articles, testimonials, research, references for further reading, connections to non-profit eating disorders organizations, links to treatment programs, and links to on-line support groups. Although not specific to males, there is much internet information that is gender neutral and can be used by males with eating disorders. The websites are also a mixture of professional information, general public information, and information specific to males with eating disorders. Most of these internet sites were found through various net search programs by typing in the key words “males (or men) with eating disorders”, “males (or men) with anorexia”, and “males (or men) with bulimia.” As well, searches for “male body image” were conducted.

4.3 Resource Needs and Issues

During the interviews, there was much discussion about the resource needs of males with AN and BN. Both the health professionals and the male eating disorder participants identified a number of issues related to availability, types of resources, what is useful and what is needed for males with eating disorders. The discussion centered around a number of main themes that arose consistently among participants. Those broad areas include format and design, focus, access and location, gender specificity, support groups, nutrition information, internet, and personal and community support. These areas are the focus of the results reported here as they were most directly related to treatment and information resource development. There were also a number of suggestions from participants for resources that might be developed, which provide practical direction for resource development. The suggestions within each section are based on input received from participant interviews and not inference by the researcher.

The symbol “HP” signifies quotes made by the health professional participants. The symbol “♂” signifies quotes made by the male eating disorder participants. The quotes are the words of a few individuals who were interviewed; not all participants have an equal number of quotes noted here. However, the quotes are representative of those themes and issues that came up consistently across participant interviews.

4.3.1 Format and Design

♂: “ So... yeah, you have to be very careful on how you present things.”

When the participants talked about information resources, there was much discussion on appeal, attraction, and promotion. An important area for examination is whether certain types of information or methods of presentation are more widely accepted and better to serve a preventive role than others (Murray, Touyz, & Beaumont, 1990). Many of the male eating

disorder participants indicated that written resources that are easy to read and readily available would be most appreciated. Written resources that are useful may be in a number of forms. Pamphlets provide a quick and easy way to communicate information. They can be general information or specific to a target group or issue.

The health professionals also discussed written resources.

HP: "Even the way we educate them. Maybe as a female, I will pick up every little pamphlet I can get. And it goes into my bag and I'll read it someday..... But I don't know if guys do that. So maybe giving out little pamphlets is not the thing to do for men with eating disorders."

That not everyone responds equally to all resource formats was expressed among the men as well as the health professionals. A health professional suggested that consistency on a national level is important. Professional formats that imply credibility were noted as important.

HP: "You don't want a whole lot of information just run.. you know, typed up and xeroxed. It's nice to have it in the form of a bulletin or... ANADs (*Anorexia Nervosa and Associated Disorders*) newsletter, it looks like a professional source that comes from a credible source."

Visual resources were discussed in terms of video and media. Again, not all resource formats were equally accepted by all people. For example, men may not be inclined to watch an educational video to help themselves with their eating disorder.

♂: "Hmmm..... I don't know. I'm trying to think, like, none of the... my male friends that I know of ever would pick up, like, documentary videos or anything."

Media was discussed as another format of visual resource. The role of media in prevention of eating disorders is not confined to the distribution of information about the disease (Murray, Touyz, & Beaumont, 1990). There was a lot of input on media from the men. Many of them looked at television media as a form of resource. The appeal of television media was that it was widespread and would be useful to communicate to the

public. Participants discussed television as appealing to people and reaching large numbers.

♂: “Everybody watches TV. Everybody. If they say they don’t, they do. (chuckle). If they don’t watch it, they hear about it. And it’s in the papers, And it’s in the.. magazines. And it’s... it’s everywhere.”

♂: “That’s why I think it’s so important for mass communications because people talk about what they see on TV. They talk about what they read in a magazine. It’s entertaining.”

Other resource formats mentioned by both the health professionals and the men were posters, bulletins, and fact sheets. “Atypical” resources included television shows (e.g., Degrassi Junior High) covering issues in adolescence. Learning from the characters’ experience was considered a resource by some of the males.

The men had much to say about what information resources should “look” like and what would (or would not) appeal to them. For example, femininely designed resources may not be appealing to males.

♂: “..... I think I had told you before that I went to a seminar... um, a graduate seminar last year on.. eating disorders. And all the... all the handouts, all the pamphlets, all the... uh... like all the pamphlets that were handed out were for women. They were pink, they were... they had little flowers on it and women dancing around and... and... and that was really offensive to me because... just that... be.. because the person that was handing out the flyers never once... you know, alluded to the fact that there could be males that had it that.. that might be a... dying with bulimia, or dealing with it.”

♂: “Because what do flowers and pink have to do with eating disorders?”

The “feminine” design of written materials was referred to by the participants. Flowers, dancing women, and pink colors did not appeal to the men. There was a comparison made between eating disorder resources and breastfeeding resources. The purpose of breastfeeding resources is obvious upon first glance and in that way may be more appealing to women. Eating disorders written resources, on the other hand, were not thought

to be designed the same way.

♂: “..... well, when you see a.. um... pamphlet on breastfeeding, you don't see all these frilly things. It just usually has a woman.. talking about breastfeeding or holding a baby or something like that. So.. it.. it attracts their attention.”

Having the design directly related to the content was considered important.

The other issue about design of information resources related to color and differentiation of target group. Availability was a more important issue than differentiating male resources by design or color. For example, if resources are presented in an obnoxious manner, it may not be as helpful as having male and female resources presented similarly.

♂: “Kind of like.. if, you know, you have men's in this bright orange pamphlet, and women's in sort of nice white or whatever. You don't have to make it stand out, but...”

4.3.2 Focus

♂: “See there's different times, different contexts for.. um.... different strings need to be pulled at different times.”

The focus of both information and treatment resources was discussed as being important to determine if those resources would be useful to individuals. Focus may refer to target groups, the issues discussed, presentation areas, and purpose of the information being presented.

4.3.2.1 Target Groups

HP: “The issues need to be individualized.”

Both the health professionals and the men expressed the view that the focus of information resources needs to be specific to groups with particular issues. Some thoughts expressed were that information needs to be individually oriented and directly relevant to the readers. As well, when the target group is people with eating disorders, concrete information

is wanted that can be applied to their lives - i.e., where to go for treatment or counseling. Health professionals thought that anorexia, bulimia, and compulsive over-eating are all eating disorders; however, each target group has specific issues. Thus it is difficult not to present irrelevant information. The men echoed these thoughts, and emphasized that specific information on focused issues is essential.

♂: “You can’t make it... you.. although you can’t make them too ambiguous and.. ambiguity is always a downfall of a lot of.. of educational materials and resources... because, you know, there’s no way to relate to it. But at the same time you can’t make it so defined that nobody will relate to it.”

♂: “Can’t deal with these issues in isolation either. Problem is knowing where to send people if they want any further information. Need to deal with these issues along with the general information.”

The health professionals discussed information resources in relation to how they meet the needs of professionals. Information is necessary to increase expertise and knowledge of the group. With respect to how the available resources are helpful to men with eating disorders, one comment was that most information resources that are available for eating disorders in general are geared for professional use; several comments focused on having more resources available for the men themselves. Health professionals expressed that a “team approach” to addressing eating disorders, both for treatment and information, is important. “Getting the agencies and the community working together” was seen as being a focus for the development of treatment and information resources for males with eating disorders. For example, education across the disciplines may be important.

HP: “I think there needs to be a lot more education in the different disciplines. I mean, right down to basic medical training - nursing, nutrition. We need to get right down.. it has to start somewhere.”

Several health professionals commented that health professionals who work with eating disorders may not be knowledgeable about males and eating disorders.

There were a number of suggestions of who should be the target of information and education. Both the health professionals and the males with eating disorders agreed that the family was a crucial target group. For example, education needs to start with parents.

♂: “..... And... parenting skills. People should... parents should really know that these... these kinds of issues should be reflected in their parenting. They should know how to deal with these kinds of issues and they should know how to identify eating disorders in kids.”

Other participants echoed this thought. For example, participants suggested that when parents make comments about children’s weight or body shape, the comments can be taken personally and negatively by the children. Striegel-Moore and Kearney-Cooke (1994) have suggested this happens with teenage girls, where parents may compare their daughter’s body to an unrealistically thin ideal and arrive at a distorted judgement of her body size. When compared with young children, adolescents report receiving the least positive evaluations, being the targets of the most criticism, the least praise, and the most efforts to change physical appearance. However, parents may influence a child’s appearance well before adolescence. Parental dieting efforts are related to encouraging the child to diet; this relationship is seen with fathers and sons as well as mothers and daughters.

Teaching parents to recognize the signs of an eating disorders, alerting them to notice the signs in their sons and not just their daughters, and offering family support resources were mentioned as ways to support family education. Educating parents about how to deal with kids and food and eating habits was discussed as important for encouraging healthy behaviors. Taking the focus off body and weight and encouraging healthy self-esteem were noted as a potential focus for information resources.

Social groups that males may be involved with may also benefit from access to information resources on males with eating disorders. Boy Scouts and Big Brothers were suggested as an avenue for early education. One way to target resources to these groups

might be through workshops for their leaders. Focusing on groups where boys and men are involved was noted as a good way to influence those who would influence the males. Another suggestion was to focus on adolescents as a high risk group because of peer pressure and self-esteem issues.

♂: “Yeah. And when people... when and I know kids who don’t know any better and they’re calling some kid fat... oh he’s fat or whatever. You know, it affects that person. Cause no one wants to be called a fat person or, you know, you’re fat. I mean I weighed 225 pounds.”

If body image is changeable coming into adolescence, it is important to understand how it can be changed and develop educational programs that focus on doing so in a positive way (Sands et. al., 1997). Adolescents with eating problems should be given resources on coping and problem solving skills to prevent the eating problems from reaching clinical degrees (Lachenmeyer & Muni-Brander, 1988). Peer influence may work positively on body image and self-esteem. Educating about anabolic steroid use, for example, may make use of peer educators. It has been thought that older adolescent male athletes who are not using steroids may function as peer mentors where they may be most able to dissuade younger adolescents from initiating use (Komoroski & Rickert, 1992).

School represents another aspect of an individual’s social environment. Because of the amount of time that boys spend in educational institutions, the focus of information and education resources was suggested to be both for the males who are affected as well as their peers and teachers.

HP: “Because I think, you know, it’s good for both the girls and the boys in the class to know that it’s an issue for both girls and boys.”

♂: “But just allow.. making sure that issue is on the forefront... of education. Well, not really on the forefront but just so it’s not hidden under, you know, way back in the back pages of a 350 page book. One paragraph.”

Self-esteem may be positively influenced by classes and education on self-concept. In a study of eating attitudes, higher self-esteem and lower anxiety among urban school children was thought to be the result of the many self-esteem messages and classes being delivered to minority youth on a regular basis (Fisher et. al., 1994). This may be another focus of information resources.

Both the health professionals and the males indicated that education about eating disorders in general is lacking, and that knowledge about eating disorders in males in schools is even lower. Focusing resources such as general information, lesson plans, presentations, and making it part of the curriculum were suggested as being useful.

♂: “You can deal with it in your science class. You can deal with it in your health class. You can deal with it in your social studies class, your.. They have psychology classes and law classes and.. and... in city schools. It’s amazing (chuckle). But there.. there’s so many different places you can put it. It shouldn’t be stuck in one little tiny...”

In terms of specific groups who might be affected by eating disorders, there were a number mentioned. Through the interviews, the men voluntarily shared their personal stories related to their eating disorder. Through their voluntary sharing of pre-disposing factors and personal situations, it was discovered that they experienced various risk factors including athletes, dysfunctional family influences, co-morbid psychiatric disorders, adolescents, and sexual conflict. The health professionals discussed these same groups as being at risk.

Related to sexuality, those men who are gay expressed strong body image pressures related to being homosexual. The gay media was noted as portraying “the image of beauty and youth” and as being “very shallow.”

♂: “..... it’s been more of an issue since I came out cause.... because of the community, the gay community and stuff..... it’s not a very large community. And there’s so much competition and you try to look your best because everything’s fashion and style and the bar (xxx). Who has the best clothes, who... who has the nicest body or...”

♂: “ This is a lot of... uh... a lot of feelings. Hurt and pain and sadness. The whole self-image. Um... you know.... gotta be thin, gotta be thin, gotta be thin. And society does that.”

Physical appearance and body image are of extreme importance in the gay subculture (Silberstein et. al., 1989). Gay men with eating disorders express that sexuality played an important role in the development of their eating disorder, and that the eating disorder may begin in response to pressures toward thinness in the gay subculture (Carlat, Camargo, & Herzog, 1997). Because of this strong competition and pressure, the men felt that homosexual males should be a target for resources related to body image and self-esteem.

4.3.2.2 Types of Information

♂: “If.. if it’s agreed upon by the professionals and educational professionals that these issues should be really individualized at that level, well great if they’re willing to do that. But.. if they can’t do that, then at least just show that those are issues which are important.”

Because the participants had very different experiences with eating disorders - the men themselves as well as the professionals in their experience with male clients - there were many issues mentioned as being an important focus for both educational and treatment resources. Most important for both the health professionals and the men was the issue of awareness. The health professionals noted that the criteria for developing resources should be to make eating disorders in males more recognized and that it is different for males and females.

HP: “I think it’s really valuable. I think it’s needed. It’s been overlooked. um.. All health care professionals have been tunneled. um.. Just because, again, stress of time and what.. maybe thinking past what lots of resources there are in literature. And it’s like ‘Oh well, it’s not an issue let’s go on.’ And um.. we need to stop and think you know maybe this is an issue.”

The men echoed the thought that awareness that eating disorders happen in men would be an important focus for information resources.

♂: “..... Yeah...Cause people just don’t really see men as having eating disorders or problems. Or that.. either that or that they can handle it. It’s just a temporary thing (sarcasm). I think it’s just sort of a... not really ignorance, but naivety.”

Both the health professionals and the men expressed that males of all ages also need to be aware that eating disorders can happen to them. Participants noted that because it is a “female disease,” men might think “Why should I as a male have it?”

HP: “And um... so it is going to be a female that’s... that’s right there. So.. it.. with that in mind, I... I don’t think that people would... see a male as having a.. an eating disorder. And I doubt that very many males, then, would recognize it themselves. Um.... They would see themselves as losing weight... or... but.....”

♂: “Yeah, I think it would... I think that a lot of men, when they think of eating disorders and stuff, they think of it as a problem that... mainly women go through. Cause again, then you have the whole body image think you know. You have to be beautiful like a model in order to be accepted. I mean that’s what.. like, men think that, you know, it’s something that only girls go through. Like men don’t have these problems.”

Other issues that health professionals noted as being a focus for information resources included concentrating on changing the future, not reliving the past, and moving beyond the eating disorder. As well, resources for facilitating change and providing skills and tools to maintain that change were considered important. Professionals noted that treatment programs that allow people to work on individual and different goals would be useful.

In terms of treatment programs, the men had had various experiences - individual and group therapy, support groups, individual counseling. However, related to focus, some of the men noted that one problem with some treatment approaches was that they did not always focus on the underlying issues.

♂: “..... there’s treatment programs but they never really identify the issues that cause it. So if you’re going to do it just once or twice you’re going to end up.. like alcoholics just keep going and going.”

More specific focus on underlying causes was noted as important.

4.3.2.3 Promoting Males to Come Forward

HP: “But if we continue to say, “This is primarily a female disease”, fewer males are going to come forward. Because how many males are going to want to be identified as having a female condition, first of all. And it doesn’t seem, or what we’re not doing is publicizing that there is help for them too. So I think we want to get away from the.. “This is primarily a female disease. There’s only 5-10% of...” We really want to get away from that and say, “This is a really serious condition, and it affects both males and females.” Forget the percentages.”

HP: “But you can’t ignore the problem if it’s there, which I guess is what’s been happening. How are we going to create the demand for more resources?.....”

The health professionals discussed the principle of “have not because we ask not”- the idea that maybe there are not any male specific resources because males are not coming forward with their eating disorder. One health professional referred to the situation as a “catch 22” - we need male specific resources to promote males to come forward with their eating disorders, but if they do not come forward, then why should we have the resources? As well, if they do start coming forward, will we have the resources to address their needs? Encouraging males to express their eating problems was then thought to be an important focus for the development of educational resources.

The health professionals discussed avenues for promoting this focus. Schools, media, and professional education were mentioned as avenues to promote information.

HP: “Well, I suppose it in schools it might be... one way. That’s where you’re.. you’re hitting most of the teenagers. At least maybe through awareness kind of campaigns.... workshops... for both males and females I think.”

Participants suggested that the media format could be useful to bring awareness to the issue and possibly knowledge of other men who have had eating disorders. Heatherton et. al. (1997) have suggested that increased awareness of eating disorders through various forms of

media may have contributed to a change in sociocultural messages about thinness. Public health advertisements, international “no diet” days, television movies, talks shows, and celebrity stories of eating disorders have been noted as examples. Heatherton et. al. (1997) believe that media focus, coupled with increased emphasis on healthful eating and regular exercise, are thought to have contributed to a decline in disordered eating behavior in some groups.

Both the health professionals and men mentioned “role models” as important influences. Seeing well known males admit to their eating disorders was thought by participants to encourage other males to do the same. Female celebrities with severe eating disorders, such as Princess Diana and Karen Carpenter, have been the focus of media related to eating disorders. They have served to increase awareness of eating disorders and the consequences of them (Heatherton et. al., 1997).

♂: “Yeah, definitely. I think so because it.. it just takes a little bit to relate. But once you can relate, that can just spark the motivation. It can, you know, (xxx) to think huh, you know. ‘That’s what somebody else went through. I can relate to that person. Where do we go from here?’”

The men mentioned personal and community support as a resource that could encourage this expression - “someone to talk to.” As well, they thought that general awareness would fulfill the focus of encouraging men to get help.

Addressing eating disorders from a prevention angle was suggested as a way to encourage men to deal with the issues that contribute to an eating disorder.

HP: “..... Oh, maybe looking at it from a preventive point of view... approaching them in their.. probably their middle or late teens... would still be good. Sort of healthy self-esteem and phase into that.. healthy coping mechanisms. Helping make them liking themselves, looking after themselves, I think. Probably preventive rather than... than after it becomes a problem.”

The men mentioned family upbringing, healthy self-esteem and self-image, and changing

societal views of who is affected by an eating disorder as ways to contribute to the prevention focus of information resources. This is supported by Neumark-Sztainer (1996) who suggests that prevention programs focus on a wider spectrum of eating disturbances and not just clinical anorexia and bulimia. Messages about healthy body image and social skills were recommended to be part of prevention programs.

4.3.3 Access and Location

♂: “Knowing that there’s even information available. Um... but how... you know, what then do you use to get that information out that there are other guys who have this problem?”

Information and treatment resources were suggested to be placed in locations that are well known by males and that are easily accessible to them. The men had the greatest input to the discussion of access and location of information resources.

4.3.3.1 Knowledge and Source of Resources

Among the male eating disorder participants, their source of eating disorders information included the library (university and public), health professionals, friends, and support organizations. Some of the written resources that they consulted included newspaper and research articles, books, fitness magazines, the internet, and journals. The health professionals noted a number of sources they went to for eating disorder resources (for themselves or clients): conferences, provincial health departments, other professionals, eating disorder organizations (such as the National Eating Disorders Information Centre, Eating Disorders Awareness and Prevention in Washington, Anorexia Nervosa and Associated Disorders in British Columbia), public health units, resource lists, catalogues, and research.

The professionals in general knew of very few male specific resources. One of the comments was that it is only recently that we have good female eating disorder resources, let alone good ones for males.

HP: “Most of the information that is distributed is... anything from association.. the Dietetic associations, or the eating disorders.. network are primarily directed at... primarily.. females. There’s very little. At least I haven’t been able to find very much at all on males.”

The male eating disorder participants also had little awareness of general and educational information about eating disorders in men, and had rarely seen any male specific eating disorder awareness information.

♂: “..... right now, as much as I’m aware of things, I don’t know of anything available for men. There may be out there, but I’ve usually come across things for women with eating disorders. So.. but again, I might be wrong. But.... you know, if a guy came to me and said, you know, as a guy where would I get help. I’d have to send them to a woman’s stuff.....”

4.3.3.2 Communicating Availability

♂: “People don’t ask for things that they don’t know about.”

♂: “It really all depends on the individual what they have accessible at their fingertips, you know.”

The men discussed that one of the reasons why there may not seem to be a demand for male specific eating disorders resources is because the men don’t know about them. That led to discussions about the best ways to let males know about the information and treatment resources available. One of the resource types that came up in this discussion was educational videos. Participants suggested that they should be shown in schools as part of curriculum to alert people not only to eating disorders in general but also to the existence of a resource. Posters could be placed in schools as well.

♂: “..... I think it (*videos on eating disorders*) should be shown in schools. I don’t think it’s just something that people just go buy. I think it needs to be sort of brought to their attention.”

♂: “..... I think it has to be shown to people, be pushed on them a little bit to make them see it’s actually.. what it’s about. Cause a lot of people won’t even identify themselves with an eating disorder.”

Research has been done on the effectiveness of video as a teaching tool. Although not specific to eating disorders, greater learning occurs when narration is accompanied by the use of video (Bashman & Treadwell, 1995). Bashman and Treadwell (1995) suggested that reading material alone is not the most effective method of teaching. Video as a method of communication allows both permanent recording and immediate playback of information. Increased concentration and attention may be fostered by using shorter videos on separate occasions.

Knowing about what resources are available was discussed as the first step to having better access to them.

♂: “..... if you don’t even know that it could be available, and you’re already afraid of feeling isolated and alienated and alone, you’re not going to go and ask for something that you never heard of. Cause people are going to think ‘What a freak’.....”

Feelings of isolation contribute to males not knowing what information resources are available for them, as well as to their hesitancy to ask for them.

♂: “Sure, but then again how do people know that they’re (*written resources*) out there. If you think you’re the only one... um... how are you going to know. I.. I wouldn’t have known ... I wouldn’t have had a clue.”

From the health professionals’ point of view, promotion of services was very important. Although some professionals receive their clients through referral (e.g., psychiatrists), others felt that it would be important to communicate their services to the public. Media, word of mouth, referral, phone books, and professional organizations were noted as ways to do this.

4.3.3.3 Presentation of Information to Clients

HP: “..... and I don’t start by giving people a lot of written information because sometimes they start reading some of this stuff in the books, and it can start to scare you. About the speculations, about the possible reasons why you’ve developed this. And it becomes very damaging, extremely dangerous.”

The health professionals noted that they hesitate to present great amounts of written information resources for fear of information overload and confusing the client. Many of the health professionals did not give any resources initially to avoid “bombarding” clients. Loading up someone with “tonnes of stuff” could be discouraging and “a real turn off” if the client is there to talk as opposed to read. Estey, Musseau, and Keehn (1991) suggest that providing simplified health information is beneficial for patients in treatment. In fact, comprehensive written material is necessary if patients are to participate in self-care activities. However, information that is too complex, with medical jargon, serves no useful teaching purpose if it cannot be understood by the patients.

The health professionals felt that giving some key information is the best approach.

HP: “..... And for me to give them a hand out that has a whole page about laxative abuse, I think they’d kind of go, ‘Whoa.’ I think a lot of times just driving home a couple of key points that they take out of the office, that they can really take to heart, works just about as well.”

HP: “..... depending on the patient and depending on their.. their, you know, their... their need for that or their desire for that, you know. But I do provide them with information. As well as the support groups and self-help groups.”

Patient need and desire for information about their eating disorder was noted as one of the guidelines in deciding what to offer them in terms of information resources. Asking them if there is information that they want and then being able to offer resources to consult was considered important. In some cases, actual nutritional treatment of the eating disorder (i.e., as with hospitalization) may be more initially important than giving pamphlets or newsletters

to read. Several professionals noted that no matter what information is presented, the client needs to think it is important for it to be useful for them.

The health professionals tended to draw on a “team approach” as a resource for their eating disorder clients. The need to consult with other professionals was noted as necessary because “it really brings to light some of the other issues” that might be contributing to the eating disorder and “how able they (*clients*) are to receive information.” Landau-West, Kohl, and Paskula (1993) support this by suggesting that a team enables sharing of knowledge to manage and treat eating disorders patients; team members experience support and shared responsibility for patients.

4.3.3.4 Anonymity and Privacy

♂: “The repercussions of well, indirect repercussions..... of coming to terms with it. So it would be... I guess, anonymity.. anonymity would be the thing that would be able to help. If you can get these resources without having everybody know until you’re ready to confidently deal with it. ‘Yes, I am bulimic. You got a problem with that?’ ‘Yes, I’m bulimic and I have a problem and I need help’, you know. There’s a big difference.”

Anonymity and privacy arose as major concerns. The more “neutral” the location of the resources, the better. Participants found it difficult to request male specific and general resources on eating disorders even if they did know where to find them. Not wanting anyone to know about their eating disorder, feeling embarrassed, not knowing which resources to ask for and “being afraid to access them” were noted as reasons for hesitating to actively search out information.

♂: “I think a lot of times men aren’t just going to go up and ask, for one..... Cause specific... it’s sort of admitting that they have a problem.”

♂: “.... some of them will feel, like... if anyone’s... happen to be looking, you know, and they’ve got this thing that says “anorexia” right on it, you know, in big, bold letters...they don’t really want to be seen with it....”

In terms of anonymity, eating disorders were compared to addictions as a way to help understand the importance of privacy.

♂: “Yeah. Cause I think that’s going to be the biggest... the biggest struggle. That’s part of the reasons, you know, that it’s “alcoholics anonymous”. Um.... and “overeaters anonymous”. And..... “gamblers anonymous”, is because there has to be some freedom there, you know.

Part of the fear expressed was that family and friends might find out about their eating disorder and react negatively. As well, having to explain themselves and why they need the information was noted as something that they did not want to face.

♂: “Well there’s a lot of people won’t even go and look for the resources because they think, you know, ‘Oh everybody’s going to see me’ (whispering) as soon as you walk into that one place. And, ‘They’re going to ask me about it. And they’re going to ask who I am. And they’re going to ask if they can help me. And that’s going to make me feel uncomfortable. And they’re going to know who I am.’ And blah blah blah blah blah.”

Resources that can be picked up quickly and put in a bag to read later on in privacy were most likely to be picked up by the male eating disorder participants.

The internet (to be discussed in greater detail in a later section) was noted as one of the best resources in terms of anonymity.

♂: “Oh for sure because the internet is making the world such a small place. You can talk to anybody at any time of the day they want to. And people are realizing hey, there are other people like me out there and when you’re... the internet gives you that.. um... confidentiality that you don’t have in person. You don’t see them. You’re not looking into their eyes. You’re not... if they judge you, you can turn off your computer and never talk to this person again, right? It’s safe. It’s a safe place to talk about things if people are (xxxx).”

Safety and confidentiality were considered important in accessing eating disorders information resources.

4.3.3.5 Location

♂: “Just have it there. Easily accessible.”

There were a number of suggestions for locations where information resources could be made available for males with anorexia and bulimia. Location was most affected by anonymity and targeting the groups affected. A few suggestions were related to health care and places where a variety of information is available - sitting out in the hospital, at an STD clinic, libraries, locker rooms, doctor’s offices, gyms, and civic centres were suggested. These locations also relate to some of the groups who might be most interested in the information - people seeking medical care, those involved in extreme physical activity, and those actually looking for information. The male eating disorder participants who were gay suggested that Gay and Lesbian Health Services would be a good place to have information that could be accessed by a specific risk group.

Schools were noted as a possible place to have information resources available. Romeo (1994) has recommended that curriculum needs to include information on how to manage weight, aerobic exercise, and proper nutrition as ways to address unhealthy eating and exercise behaviors. As well, information about the detrimental effects of AN and BN is indicated as students are often the first to recognize an eating disorder in their classmates. However, participants suggested that schools currently may not be filling the need for eating disorders information.

♂: “More anonymous resources. Like the ... if the school would have had.. like a little section.. a learning resource section that would have had pamphlets or flyers or books on such. Our school didn’t have that. Yeah, I checked out school library because I said I was doing a project on this, and I was worried my aunt was going to find out that it was just about myself. So I went to the library, our school library, and tried to find any information that I could. And I wanted to, like, say ok, this is what I thought. I didn’t find anything! There was nothing there to find. Um.. there were probably, like, a few things in health books, like I said, but that was only, like, one or two pages. And I wasn’t going to go ask our phys ed teacher or science teacher or anything about that, or home ec.

teacher. Cause I was.. like I was really good friends with them. And we had the respect thing going on.”

Accessibility of information was an issue when participants did not live in major urban centres. Location of the men who are affected and not just the information itself played a factor in knowing what resources were available.

♂: “But.. yeah, resources which I had access to were basically not much... In rural Saskatchewan, there’s not much out there for eating disorders. You’re just basically trying to keep.. Well, where I come from, you’re just trying to keep people from committing suicide and keep people from becoming, um, major substance abusers. Catching.. basically HIV from sleeping around or having babies when you’re 15, so..... And that (*eating disorders*) wasn’t really seen as, um.. an issue.”

The way that information resources are laid out was mentioned as affecting perception of the issue. Having both male and female information available in the same place was suggested.

♂: “I don’t know about a separate stand, but..... it’s just kind of... if you have both things side by side, you know. You know, it (xxx).. it shows an equality between the two. That both are ... the same.”

4.3.4 Gender Specificity

♂: “Um..... well, yeah I mean in the same way that.. uh... I think that it was helpful for women to have their own resources I think that it would also be helpful for males to have their own.”

There were a number of opinions from both the health professionals and the male eating disorder participants about whether treatment and information resources should be gender specific. Some participants thought that there needs to be male specific (and exclusive) treatment and information resources so that the specific issues of males are addressed. Others thought that female resources work just fine, as many of the issues are the same and many of the men could relate to women easily. Others thought that the best resources were those that said neither “he” or “she,” but rather were gender neutral.

Regardless, research suggests that increased knowledge of normal behavior in males and females would lead to an increased understanding of the contributing factors to disordered eating behaviors would be extremely important in designing gender appropriate treatments (Rolls, Fedoroff, & Guthrie, 1991).

4.3.4.1 Male Specific Resources

HP: “But certainly there probably is a need for resources in that area.. specifically for men. Because you can’t keep showing the stuff for women in looking at women’s issues and... you know, it’s not going to work.”

Several health professionals and men thought that male specific resources would be needed to encourage men to deal with an eating disorder. Because men have specific issues to deal with related to having an eating disorder, resources may need to focus on specific male issues.

HP: “Or maybe, on the other hand, we don’t know much about.. well, I guess because I don’t do much reading in this, but maybe the resources that are made with the females in mind are not going to hit the issues that the males need to know about. I don’t know. I don’t know. There’s different issues that males need addressed than what the females get in terms of resources.”

Intervention programs, for example, that address self-esteem and self-efficacy may need to address males and females separately where these issues may be manifested in different ways by men and women (O’Connor, Friel, & Kelleher, 1997).

Where men do have specific issues to deal with related to their eating disorder, sometimes different than those for women, mixed-gender treatment resources may contribute to feelings of isolation. If their issues are the same as some women, the perception that males do not experience eating disorders contributes to feelings of exclusion.

♂: “Like, I go once a week, and about 3 hours every Thursday for the child abuse crap in my past life and..... and it doesn’t take much to trigger that. Like, and.. Someone will start talking about that and.. And.. In the group. That’s happened... And I feel out of place when that happens.

It's like, it happens to women. You know, it's not something that happens to the men. And if it does happen to the men, there's a difference."

With support groups, for instance, the question of having sufficient numbers of males in any one locale to have an all-male support group was raised. Both the men and the health professionals recognized that it would cost money to create resources for every specific group. The health professionals brought up the concern of the cost-effectiveness of having a great amount of specific resources for a seemingly much smaller population of people.

HP: "Which probably puts the numbers pretty low. So just cost-wise, I don't know if it's cost effective to have... lots of specific resources..... I think there has to be.. yeah, you have to consider how many people are actually going to benefit and if your time is worth putting, you know... worth putting the time into that. Yeah. I mean it certainly is if one person benefits, but it..."

Even so, there were a few health professionals that felt that having resources specific to males was important, regardless of how many people would benefit from the resource.

HP: ".....And because.. um.. anorexia has a lot to do with body image, etc... um.. you know, the picture of the.. of the female doesn't exactly.. um.. wouldn't exactly be what you would want to provide to the males with an anorexic problem (chuckle/sigh). Um.. so yeah, I'm sure there's a need for.. for that. Even though we don't have a huge percentage of the population that would require it. Uh.. if we only have one, if we can help that one person, then we need to do it."

Several health professionals did express that it is difficult to offer male specific resources because they know relatively little about males with eating disorders. Because there has been little long-term follow up with males, and because the numbers of male patients and professional experience with males on the whole are small, it is difficult to know what resources to offer male clients.

HP: "But we really don't know about some of these underlying issues, and what do they really need. What kinds of things... would be helpful to them. It's nice for us to..... be here and say, "Well, we can do this and we can find this out for them." And yet we don't know what some of their

issues might be. Are they different? And it sort of goes back to sort of, going back to the same thing again. Are they different? Are they the same? Some things are generic. Some things are not.”

The language of resources was a concern of participants. The use of the word “she” in resources was mentioned as contributing to the perception that eating disorders are a female problem. Both the health professionals and the males expressed that men might find it hard to relate to resources that are always written in the feminine sense.

♂: “I mean, I think if there was just one.. even a pamphlet, that just sort of said, you know..... ‘If you’re a man who has an eating disorder, you know, there are men who have eating disorders and..’, um.. you know, even if you just took out the ‘he’... the ‘she’ and put ‘he’ ”.

Some of the men expressed feeling offended and bothered when presented with female information resources.

4.3.4.2 Female Specific Resources

HP: “Yeah. Yeah. And you read something about anorexia somewhere, it’s always a female. You hear something on the TV, it’s always a female that they use.”

Both the health professionals and the men agreed that most information and treatment resources currently available for people affected by eating disorders are geared towards women. The health professionals indicated that it would be good to have more research and literature on males with eating disorders. They noted that many of the information resources are written mainly for women, with infrequent mention of males who might be affected.

HP: “Cause there’s always only one line for men - 1-3%.....That’s all, you know, for a whole article. They get one line, and the rest is about females.”

Many men also stated that most of the eating disorders information that they have found and read has been geared for women. Even information about awareness of eating

disorders has been female specific.

♂: “Uh, in general there is, yeah. But I... I’ve gone to various clinics, and I see information there. Go to the libraries, there’s a lot of information there. But, um... but personally, I find a lot of it is geared towards women. A lot of it at times is not really thought of as a problem that a lot of men have...”

Some of the men felt that information and treatment resources that are geared for females would serve just fine as resources for them as well. Because many of the issues that contribute to an eating disorder in men and women are similar, it was felt that the same information would apply. Some of the homosexual participants felt more comfortable with female-directed information.

♂: “Because..... this is where a lot of gay men would probably relate better to the women’s issues and to the..... educational resources or materials for women because they can relate to the feminine side.”

The gender focus of the information resources did not matter to several of the men.

♂: “..... For myself, I don’t really it would matter so much if there was one for men and one for women or just, like, a non-gender specific.. sort of a.. as long as there’s something there that’s aimed either directly towards someone or so they.. just people in general.”

It may be more important for some men that there is something rather than nothing available, even if it is geared for females. Many men did express that “female oriented” information they had read was somewhat helpful.

In discussing women’s eating disorders education resources, many of the health professionals felt that they could be used with males. Some adaptation and revision might be required. For example, when using lesson plans or manuals with groups of males, changing the language from “she” to “he” or using neither might be useful. However, using female oriented resources for males would require adaptation for the males.

HP: “Yeah, and I think a lot of the material could be revised.. and worked so that it could be read through a males eyes. And not have every second word be ‘she’ and, you know, this. And it’s harder to, I think, connect with some of the.. speaking more.. not all the resources, but the written resources if that.. um.. if it’s easier for them to identify that, you know, this can be happening to them, not... you know.. just a ‘woman’s problem””.

HP: “So if you want to use any of that (*female specific information*) information as a resource for males, you pretty much have to go through summarizing the information and re-write it yourself. Because you really can’t just hand out information that continually refers to females.”

A couple of the health professionals did not think that male specific resources were needed. It was suggested that health professionals run the risk of being too gender sensitive, and that using female resources would work just fine for the males.

4.3.4.3 Non-Gender Specific Resources

HP: “..... I can’t think of a lot of... any of the things that I use are, sort of, in general. It could be, you know, not really gender specific.”

Many of the health professionals and men felt that non-gender specific information and treatment resources would be most useful and applicable for addressing eating disorders in males. For example, one of the health professionals compared eating disorders with other medical conditions, such as heart disease or diabetes. Because some conditions related to physical health are not specific to gender, it may be that treatment approaches do not need to be so gender specific.

HP: “So is it the kind of, you know, subject material, like diabetes, for example. I mean, if I have a room full of people who have been diagnosed with diabetes, it doesn’t matter what their gender is. And when you get into the one-to-one meal planning and, yes some of their.. um.. obviously there will be some individualization within their individual lifestyles. But does the education really require that kind of gender specific. Like I said, with renal disease or diabetes or cardiovascular disease, it doesn’t. I mean, we’re talking principles..... because the first thing you’re trying to do is control the blood sugar or control the renal disease or get the ulcer under control or get the heart disease, you know, so that there isn’t.. it’s

not really that gender specific. Whereas, I guess, this, if it deals with body image and self-perception, probably does. So.. so I don't know."

Body image and self-perception play a role in the development of eating disorders, and may need to be addressed gender specifically. However, it may be that because these basic issues are common in both men and women with eating disorders, the two genders can be addressed together.

HP: "Cause I'm not.. just off the top of my head, I can't think of another one that.. is specifically for males. I think a lot of the issues, though, in terms of control and body image, self-esteem, I think that a lot of the information really could be generic. But their main.. in terms of the sports component, that may need to be addressed separately - the competition and the.. the sports area - which would affect some of them more.. more intensely than females. But I think a lot of the issues are really similar. Just like when we talked about obesity and anorexia and bulimia. The issues are very similar. I think those are.. not gender specific."

There may be no clear indications to suggest special treatment techniques for male patients with eating disorders (Steiger, 1989). Steiger (1989) suggests that multi-modal treatments including biological therapies, psychotherapy, skills development, and social reintegration may be most appropriate. Specific issues, such as identity problems in males related to their eating disorder, may have to be particularly emphasized with male clients.

Some of the men also felt that non-gender specific resources would be best. One suggestion was that information that is not so "gender biased" is more appropriate than having male specific information in some cases.

♂: " none of the materials she handed out were not even male specific but... not that they were not male specific, but they could have been not so gender biased. Like they could.. they didn't have to be just for women. It could have been just a pamphlet on bulimia, the same way it could have been on... on AIDS, you know....."

There may be problems with non-gender specific information, however. Although some men might be able to relate to it better, the problem may be that it is too general and

vague to be practical.

♂: “Yeah. I don’t... I’m not opposed to having it in each area. Because if it is non-gender specific, then it’s a little bit different from getting.. um.. relating to or identifying with, you know..... It’s like trying to relate to something that’s so general.. too general..... Yeah. Too vague.”

The benefits of non-gender specific information to males with eating disorders is reflected in the following comment:

HP: “Yeah. Um... and I .. I guess if you have the feeling that the.. the disease you are afflicted with was something that could be.. that anybody could.. could be affected with, you would be much more likely to... come out and talk about it than if you thought you had a disease that everybody perceived as being a female disease and you were a male..... Just like vice versa, you know (chuckle/sigh).”

Both the health professionals and the men felt that accommodating both sexes rather than focusing on “95% females” would be a helpful approach to information and treatment resources. The risk of separating males and females for education, for example, may be that we further emphasize that it is a female condition. Removing the label on eating disorders as a “female condition” would be the goal of non-gender specific resources. It is crucial that people of either gender be empowered with the skills to overcome the cultural, interpersonal, and developmental influences that may negatively affect body image (Cash, 1997).

4.3.5 Support Groups

♂: “.....support groups are nice and there’s a time and place for them.....”

Both the health professionals and the men talked a lot about support groups and the different issues surrounding them. The main issues included gender and problems with support and self-help groups. Overall, the health professionals had recommended support groups a number of times to their clients, and some had been a facilitator. Of the men, most of them had personal support group experience, but differing opinions on their usefulness for

addressing eating disorders.

4.3.5.1 Gender-Mix of Support Groups

HP: “If there were enough guys to have one. I don’t think they’d feel comfortable with the girls. And I don’t know if the group would feel comfortable with them.”

There were differing opinions about all-male compared to gender mixed groups. Both the health professionals and the men expressed that in some cases, an all male support group would be most beneficial. But as with developing information resources specifically for males with eating disorders, both groups also questioned whether there would be enough men with eating disorders in one location to have an all male group.

Some of the men said that when there are women involved with the group, they may hesitate to participate actively in the discussion.

♂: “I grab the chair in the corner and I sit there and I keep my mouth shut. I just can’t, you know... I won’t even admit to it. I’m there, I’m admitting to it by being there. But I guess I figure that somehow that’s good enough. To talk about it... uh uh.”

Related to “hiding in the corner,” the thought of expressing issues about their eating disorders in a group setting concerned a number of men. Some of the men considered that where support group settings would be fine for some, they would not be applicable to everyone.

♂: “Well, some... there’s always going to be this few that don’t do the ‘talking groups’ thing. Cause, you know, it reflects on their ‘machóism’”.

One of the men related his experience going to an overeaters anonymous group and experiencing gender barriers. When he had heard about the group and was excited that it might help with his bulimia, he found that when he arrived it was not a comfortable environment.

♂: “It would... if there were other men there, it would have helped if... um.. and it was nothing they did. They didn’t do anything wrong. But just all of a sudden I’m in this room with all these housewives.”

The health professionals agreed with much of what the men said about support groups. Some of the professionals shared the concerns about mixing males and females in a support group. There was concern expressed about males being accepted by females in a group and integrating into group dynamics. For example, men involved in a multi-gender support group may develop a sense of shame about their eating disorder, where the perception that they are “like a woman” is accentuated. However, there were thoughts that men could become valued members of support groups and foster a different social environment that would make women feel comfortable. This is supported by Woodside and Kaplan’s (1994) finding that males were able to be treated successfully in a mixed-gender therapy group.

4.3.5.2 Problems and Issues

♂: “Hmmm.... I don’t like self-help groups at all.”

Many of the men did not like the idea of support groups. They had several problems with the group setting. For example, some felt there was the potential for co-dependency, which can occur in self-help groups.

♂: “There... there’s.. all the self-help are basically structured around co-dependency. And it... it’s... I see it as being harmful and not being helpful. I see... I see structured therapy and counseling as being.. um... more beneficial.”

Some of the men felt that support groups would not be productive when they become simply a group of people complaining about their lives. A couple of the men expressed that they don’t like to burden other people by “laying out” their problems. One man felt that facilitation by a professional would help make the group more useful.

♂: “..... if it was lead by..... a licensed therapist, you know that’s.. that’s..... trained in group dynamics and can structure, you know, can structure the group..... I don’t really see getting together and complaining about their problems.... like which self-help sometimes turns into.”

Support groups can either be encouraging or discouraging for those who are involved. Some of the men felt that their motivation to get over their eating disorder could be directly affected by the health status and progress of other members of the group.

♂: “But I see a lot of people in that group who just simply, there’s just no change. Now..... so I end up just saying ok, well I guess not... what’s the point.”

When other members of the group do improve, many of the men felt that this was encouraging to their own situation. Having “recovered” guest speakers come to the group was one situation that was mentioned.

The issue of expression and ability to feel comfortable in a group setting was a concern of a number of men. Disclosure of eating problems could be risky when done in a support or self-help group.

♂: “I always have a sense of being... if I say something that I’m going to be judged for what I say. I would like... I guess for me it would come down to being able to be in a situation where I can talk about whatever, absolutely anything and not worry about this. I’d give up a foot for that (chuckle). But I’m always concerned about that... appearances, dealing with everything, always about... about that. I would like to be able to just be comfortable with, um... a situation where you could just sit and talk and not... I just... not be worried about...”

When there are shared experiences, identification with the feelings that are involved, and a sense of safety were mentioned as being needed for feeling comfortable in a support group. Letting people know the details of the support group before coming - format, how the group would be run - were suggested to increase the sense of safety.

♂: “..... Instead of them coming to the support group cold, they were given information beforehand that would outline the things we would discuss, the goals of the group, that they’re.. that everybody there struggles with an eating disorder. I think that would probably make it a safer place.”

Some of the men and health professionals felt that support groups would be helpful for dealing with some issues. A few men said that they would not be deterred by having females in the same support group. As well, the feeling of support not specific to a support group was seen as the most important factor for dealing with an eating disorder.

One of the risks of support groups and disclosure of an eating disorder mentioned was “learning” how to “do” the eating disorder from friends or others who have it. One man mentioned the risk of “picking up tips” from other members of the group on dieting and losing weight.

♂: “..... I don’t go (*to the support group*) with the intention of picking up information to (*tips about doing the ED*)..... but if it comes out, or if something goes by that... I... this, that... I probably get more out of that than I do anything else.”

A comment made by a few of the health professionals relates to combining the different eating disorders in the same group. When anorexia, bulimia, and compulsive over-eating are all dealt with in the same support group, there may be the danger of misinterpretation of information - i.e., cutting down on bingeing may get confused with dieting. It was thought that a facilitator would be needed to clarify any misconceptions and misinterpretation of information.

4.3.6 Nutrition Information

♂: “... but I didn’t really.. that information alone wasn’t enough to stop me.”

Both the health professionals and the men discussed nutrition information and its usefulness in addressing and treating eating disorders. There were mixed opinions about the

importance of nutrition information - in both groups, some felt it was the best kind of information, yet others did not think it was very useful. There was input about the benefits and the drawbacks of offering nutrition information to males with anorexia and bulimia.

4.3.6.1 Benefits of Nutrition Information

♂: “So that whole concept of.. looking at food in that way kind of.. overwhelms me.....Help if... if there was, like, a sheet made up. These are healthy foods, these are bad foods. Separate them.”

Some of the men expressed that they would find nutrition information very helpful in dealing with their eating disorder. They noted a number of benefits to information about healthy eating and Canada’s Food Guide. A few of the men found it confusing to learn about nutrients and foods that are good for you. They wanted information on different sources of nutrients and what they do for the body. Knowing how to put a healthy diet together and how to steer away from “junk foods” were noted as the kinds of information that would be useful. One suggestion was that nutrition information is useful combined with general information on eating disorders. For example, starting a healthy eating pattern was noted by most men as making a difference in starting to get their diet back on track. Educational programs that describe the physical consequences of an eating disorder as well as nutrition have been suggested (Lachenmeyer & Muni-Brander, 1988).

The health professionals saw a number of benefits in using nutrition information to address eating disorders in their clients. They emphasized that nutrition is vital in caring for critically ill patients to re-nourish them. As well, using Canada’s Food Guide to get patients back on a healthy diet might be a good approach - patients may accept it because they have heard about it before. Nutrition information was noted as being mostly non-gender specific. For some of the health professionals, the use of nutrition information with eating disorder clients may depend on their health status. Patients who are hospitalized may have re-feeding as a top priority. Other clients may start with learning how to put a healthy diet together.

HP: “Once someone comes into hospital, the focus, at least what we’ve had our focus as being, more that we try and get them on three meals a day. If it’s anorexia, three meals a day. And snacks, if they require snacks. If the person’s bulimic, still the same kind of thing - getting them on three meals a day, and usually trying not to have any snacks in between.”

HP: “..... your approach in hospital vs. outpatient is very different for what you’re trying to accomplish. You’re trying to medically stabilize them, and maybe get them, you know, um.. whether it needs to be for weight gain purposes or.. um.. stabilize eating so there’s no vomiting and their electrolytes back in balance, you know. It’s very different from the approach we take where they’re.. you know.. in trouble but maybe more medically stable as in outpatients.”

Some approaches mentioned include working in steps and setting gradual goals of decreasing eating disordered behaviors and increasing dietary intake.

4.3.6.2 Drawbacks of Nutrition Information

♂: “She, uh... I guess with seeing a dietitian..... it’s kind of a waste of time if you’re not going to adhere to... you know, the information... I mean you know what types of foods you need to eat, and... you practice the eating... you practice the eating disorder as well. I’ll take my B-vitamins now at least, I suppose.”

Participants discussed some of the drawbacks, or weak points, of being offered and using nutrition information resources to address their eating disorder. The main issue that some of the men brought up was that simply being offered nutrition information was not helpful because it does not address the underlying issues of why there is an eating disorder.

♂: “Cause it’s not always just the nutritional... ‘Oh you have to eat’. It’s like, well, I know I have to eat. And I can eat. But that’s not going to change my mental attitudes towards it.....”

Nutrition information alone is not going to help a person deal with the core issues. One man commented that even if the eating disorder goes away, the unresolved core issues might lead to other problems.

♂: “Well, yeah, but you see that doesn’t get to the core issues. I mean the core issues is... see if you do that then all you’re going to do is get... you get people to eat healthy and maybe they will. But then they’ll become sex addicts.....”

Participants expressed that when they were (or are) going through their eating disorder, they knew what a healthy diet is and what foods were nutritious. However, the knowledge alone did not make the difference in their dieting habits, that “nutrition without understanding why (*they’re*) doing it would not have made one bit of difference.”

♂: “... I just don’t. And when I’m not.. well I don’t purge anymore, do the bulimia thing anymore, but... um.. even then I knew it was unhealthy. I knew all the information about nutrition... what.. um... what’s that called... denying myself the... nutrient value of certain foods and stuff. I knew what it was going to do to my body...”

Some participants felt that nutrition information should not be a priority in addressing the eating disorder, but it should be used in combination with other therapies and resources. Balancing the core issues with getting nutrients into their body was noted as necessary for improving their overall health. They expressed that even if you do deal with the core problems, then you still need to know how to eat a healthy diet and put together well balanced meals.

♂: “..... Just educating somebody about eating, I think that needs to be part of it, but it needs to be a multi-tiered approach. Because... and I also don’t think that dealing with the problems is enough. If you... I bet if you’ve been a ... bad eater, then even if you do deal with your core problems you still need to be educated on how to... you know, good nutrition and eating well and eating balanced meals. Those kind of things.”

A few of the health professionals discussed that one of the dangers associated with nutrition information is misinterpretation and misinformation, “people trying to go on a diet without the proper help.”

HP: “..... perhaps some misinformation from the coach. um... It um..... and probably too, the general concepts of.. uh.. the public of.. you know, sweets make you fat and.. and starches make you fat”

Misunderstanding of nutrition information was thought by a few of the professionals to contribute to excessive and dangerous dieting practices, pointing to the need for reliable nutrition education as a preventative measure. Misconceptions about dietary practices may be a particular danger for athletes. It is a major concern for those intercollegiate athletes who do not have adequate nutrition information and who are simultaneously restricting their food consumption to meet the demands of the sport (Enns, Drewnowski, & Grinker, 1987). The teacher or coach has been identified as the most likely person to be encouraging athletes to diet. Therefore, guidelines need to be established to enable coaches and athletic trainers to assess their athletes for possible dysfunctional eating behaviors (DePalma et. al., 1993).

4.3.7 Internet

♂: “I saw... I downloaded a few things and uh..... posted a... note on the... newsgroup.....”

Both the health professionals and the men discussed the internet as a source of information and self-help resources for dealing with eating disorders. Issues addressed included the types of information available and the benefits and drawbacks of using the internet.

4.3.7.1 Types of Internet Information

HP: “..... So if somebody had an eating disorder and they were on the internet looking for what they have, it's very general information. But not much professionally.”

Both the health professionals and the men had sought information on the internet to some degree. The health professionals felt that much of the information that could be found on the internet was general and mostly written for the lay public. They did not discuss resources that professionals could use for treating males with eating disorders. There was

mention, however, of searching for information on the internet to find out what would be available for distribution to patients and the implications of the internet for the men themselves.

The types of information the men thought would be useful or that they had found were varied. Several men had used the internet for general information, as well as self-help types of resources. Articles, general information about eating disorders, and research were all noted by the participants. Information on the classification of eating disorders and ways of diagnosing them were noted as helpful for better understanding eating disorders in general. Having statistics to qualify their concerns and build their confidence to admit to an eating disorder was mentioned as a specific type of information resource. As well, specific internet sites, such as “Med Access” and “Something’s Fishy,” were mentioned as having good information on men and eating disorders.

Another type of self-help resource mentioned was testimonials from others who had suffered eating disorders. Hearing the personal stories of other men who had experienced eating disorders was considered helpful. As well, on-line support groups were noted as a resource.

4.3.7.2 Benefits of Using the Internet

♂: “And, you know, now that it’s anonymous, nobody can see what you’re looking up, you know. You can get information and as long as it’s accurate information, I guess that should be regulated. But yeah, I think.. um... it’s.. it’s a much more impersonal but it’s also much more confidential. So I think that is a good resource.”

Many of the men discussed the internet as a fantastic source of information and self-help resources for dealing with their eating disorder. The main benefit mentioned was anonymity. Because anonymity was discussed as important for accessing both information and treatment resources, the internet was thought to be an additional resource for this reason.

♂: “Sort of helping people open up a little bit more. Cause I know that people tend to open up when they’re totally anonymous. You know, no face, different name. And they can just turn it off whenever they want.”

The other major benefit to using the internet as a resource for eating disorders is in reducing feelings of isolation. Testimonials of other men who have anorexia and bulimia were thought of as helpful in allowing men to realize that there are other men with eating disorders.

♂: “... So it...a but it was helpful to ... I had already known that it.. that it does occur in males, but it just sort of.. um... helped to reaffirm that in my mind that yeah, ok, this does happen. And I’m not.. extremely abnormal or anything (chuckle) like that. Um... and I’m wondering.. uh... I think in town there’s some... there’s support group or something like for males as well isn’t there?”

♂: “And I... it gives you that little boost of confidence, that, you know, it’s not just me. So there’s nothing wrong specifically with me.....”
As well, the issue of safety in disclosure to on-line support groups was noted.

Because the interaction is “impersonal” through a computer, a person can feel comfortable without fear of personal judgement for having an eating disorder. On-line support groups were seen as a different type of disclosure than face-to-face interaction.

♂: “ Oh for sure because the internet is making the world such a small place. You can talk to anybody at any time of the day they want to. And people are realizing hey, there are other people like me out there and when you’re... the internet gives you that.. um... confidentiality that you don’t have in person. You don’t see them. You’re not looking into their eyes. You’re not... if they judge you, you can turn off your computer and never talk to this person again, right? It’s safe. It’s a safe place to talk about things if people are (xxxx).”

The health professionals commented that disclosure over the internet might not be as threatening as face-to-face interaction. As well, initiating communication with health professionals through the internet was one way to promote men to come forward.

HP: “ They can do it anonymously. If it was, you know, like a (xxx) to some criteria of eating disordered or distorted eating habits. And um.. see the numbers that you might get through there. And then contact them for further follow-up... of what kinds of things they might like to see for resources too. I think sometimes we’re trying to decide what’s good for them.”

4.3.7.3 Drawbacks of Using the Internet

♂: “..... research on that thing is often problematic.”

The major drawback about the internet mentioned was that the information and the sources are often difficult to verify as accurate and credible. As a way to counteract this, one of the men indicated that he looks for research names that he recognizes from other sources when looking for information on the internet.

The other drawback about the internet is that not everyone will have equal access to using it for information or self-help resources.

♂: “ Internet is good because it’s anonymous, but we have to consider who has access to the internet. Not all people affected by eating disorders will have access..... and so it wouldn’t matter to them if there are male resources there or not.”

4.3.8 Personal and Community Support

♂: “..... it helps to have someone to talk to.”

When asked about resources that would have been helpful when their anorexia or bulimia began, participants consistently mentioned the need for support on both the personal and community level. Friends, family, role models, and formal programs were all noted as sources of support. The main issues around support resources were disclosure and various support networks.

4.3.8.1 Disclosure Issues

♂: “After I disclosed it I felt comfortable sharing after that point.”

Participants expressed that one of the most difficult issues in dealing with their eating disorder was disclosing it to others. Many of them had not disclosed their anorexia and/or bulimia to many people outside of their treatment team or very close circle of personal support. Reflecting back on disclosing his experience, one man noted that it was “the hardest thing I ever did at that point in my life.” However, the men did acknowledge that disclosure was the first step to addressing either anorexia or bulimia.

♂: “I mean, just... it makes me aware of stuff by saying things, more so instead of thinking.”

Several reasons were given for disclosure being difficult. Primarily, the fear of judgement and sense of shame made the men hesitant to tell anyone about their experiences.

♂: “Well, the disclosure, the shame of having a problem..... Every... guys want to say, “Oh, I’ve got my life under control. I, you know, I do everything on my own. I’m independent”, blah blah blah blah. It’s that fear of disclosure and being ashamed that you do have a problem and that you don’t have the perfect little life and you’re not in control..... And disclosing a problem like that or a symptom of a deeper rooted cause would be... making yourself ashamed would be embarrassing”.

However, as difficult as it may be to disclose an eating disorder to people, that was seen as needed the most to start addressing an eating disorder.

♂: “Information. Sensibility. Someone to talk to. Let go. It’s hard to.”

♂: “..... and I had just become a Christian... um... but that ... that was really when the change started.... But I think it would have come a lot faster if there was somebody who could have helped me come to the understanding about a lot of the things that I came to...”

Being comfortable with someone and knowing them well on a personal level were

discussed as being necessary for complete disclosure. Some of the men felt that disclosing the eating disorder to friends or other people close to them was easier and more productive than disclosing it to complete strangers.

♂: “It’s easier when you’re more comfortable with somebody. I find it hard to come to a group and then expect to be able to relate to them just because we have one small thing in common.. you know.”

Trust, confidence, and feeling comfortable with the people you are disclosing eating problems to were noted as crucial. Most important was being able to talk about it and having an outlet for doing so. Freedom, honesty, and a sense of relief were noted as the main benefits of being open about an eating disorder. Lack of communication and feelings of isolation were mentioned as the most difficult issues to deal with related to support. All of the men agreed that it is “healthier to talk about these issues.”

4.3.8.2 Support Networks

♂: “Yeah, somebody you could go towards for support and guidance. And somebody who wouldn’t... cause you’re always worried about the disclosing and the shame and not.. holding into norms and all these little obligations that are bestowed upon you as a male. But yeah, if you... if you had somebody who could say... identify. You need to identify so you don’t feel alone, you don’t feel isolated.”

When participants discussed support networks, it included individuals, family, friends, and other social groups. The “network” involved both knowing other people in personal life and the community with eating disorders, as well as knowing who and where to go to for support. Having support and not feeling alone was felt to be necessary to prevent eating problems from getting worse.

♂: “..... Anything helps that I’m not alone, yeah. That’s the primary objective, I guess. Yeah it doesn’t work to... where the time I spend by myself (xxx) I get in too steep. I have to recognize that and do something about it now.”

Not all of the men had family support when they disclosed their eating disorder. Sometimes

their eating disorder “got lost” in the shuffle of other family problems. This contributed to the eating disorder, making it more difficult to address.

Friends were seen as a very important support resource. Having the confidence to be able to talk about your problems with friends and ask for their advice was important to many of the men. Felker and Stivers (1994) identified a number of deficiencies in the family environment of adolescents at risk of developing eating disorders. These deficiencies included low cohesion, low expressiveness, low organization, and low independence. Improvement of interpersonal skills, self-concept, and organizational skills were thought to impact the family in many positive ways. Expressiveness may be enhanced by improved communication skills including attending, following, and reflecting. Improved communication skills may be a goal for improving the likelihood of disclosure of an intimate problem or struggle.

Opinions among the men differed as to whether it would be easier to disclose an eating disorder to a female or a male friend (or stranger). Having social support from groups of people who have commonalities was noted as being a community support resource.

♂: “..... when it was happening with me, it was a.. like, I also needed a lot of.. uh... social support... from other people. Like group aspects... you know, commonalities or... just people in general. Just someone to go and sit and talk with for a while.... about your own problems or... or whatever.”

Using a support network for dealing with an eating disorder was compared to Alcoholics Anonymous and 12-step programs by a few of the men. They suggested that having a “buddy system” set up where friends could support each other through an “episode” might be useful.

♂: “Well, she.. you know it was kind of funny because it ended up being kind of like a... like an AA partner or sponsor, you know. When I was having difficulties, I... I felt safe going to her and saying listen, you know... it happened, again. And, you know, what should I do... her being so familiar with all the... with all the aspects of bulimia and anorexia, you

know. She said..... you know, “Just calm down”..... she gave me a lot of materials to read about males and bulimia. And, you know, she said that it’s natural, it’s a natural thing to go... to have this relapse.”

Several men thought that although friends and family are a great source of support, there is the potential for “emotional overload” when it comes to dealing with eating disorders. There seemed to be a delicate balance between people showing that they care and the men feeling like there is too much attention on the topic.

♂: “ But just, kind of, the degree of how much it is. Like how open do you have to make the topic? Start to find out why these things are happening. So, like, you don’t have to go and call your friends and, ‘Oh, so and so is not doing this. So I’ll go over there and be with them and give them support’ and all this stuff. Cause he doesn’t want that attention.”

4.3.9 Suggestions for Developing Treatment and Information Resources

♂: “Well, yeah, you’re never going to force someone to read it. So.. or absorb it. So but as long as it’s there, you know, if they ever... feel that they want to suddenly, you know.. you can have it there ready for them.”

Both the health professionals and the men had suggestions for the types of resources that are needed and that could be developed. Both groups agreed that it was important to increase awareness among the public, professionals, and males that AN and BN happen in males.

4.3.9.1 Suggestions from the Men

The male eating disorder participants had several very specific suggestions for treatment and information resources that would be useful for them in dealing with their eating disorder. As well, their suggestions were for resources that would help other men and the public to be aware of eating disorders. Specifically, the ideas focus on awareness of who is affected by eating disorders, written resources, support and communication, and media.

1. Who is Affected by Eating Disorders

♂: “So you could use men, women, you know... small people, big people. Everyone and anyone. I think it would.. I think it would be a really positive project.”

Participants discussed one of the most important issues in developing resources as creating awareness of the people that can be affected by anorexia and/or bulimia. The image that eating disorders only affect women and result in an emaciated “skeleton-like” body contributes to a very narrowly defined perception of what an eating disorder “looks” like. One of the suggestions was to develop awareness materials that would counteract this image.

♂: “Yeah (quietly). It’s like... I think a lot.. if, um... what a lot of media.. well, not so much the media but the information package should do is not just show the... what some people look like with.. when they’re anorexic. It’s like show us not just these totally skinny people that are anorexic, but.. it’s like, just.. go to normal people. Like... “My name’s G and I have anorexia”. Well, you wouldn’t know it to look at me. Cause that’s not the look that people see for anorexia. They see little skin and bones people. Cause that’s all they’ve been shown.”

Basically, the idea would be to show that eating disorders can affect men and women, gay and straight men, children and adults, and that a variety of body shapes and sizes may be indicative of an eating disorder.

By increasing awareness that eating disorders do happen in many types of people, especially men, one of the benefits noted would be to allow men to realize that they are not the only ones dealing with an eating disorder. Sometimes it may be that it is difficult for the men to realize that they are not alone, and in that way awareness information would help both the public and the men themselves.

♂: “..... but that was the hardest thing for me, to... to understand that I wasn’t the only guy that.. that was going through this. There are other guys. And there’s actually a lot of other guys that are going through it. Whereas I think with women it’s.. uh.. you know, it’s in the media all the time. It’s uh.. you know, there’s jokes made about it all the time.

There's .. uh.. it's not really all that unusual to hear of a woman having bulimia. Or anorexia. So... not that it diminishes the severity or the... or anything like that, it just..... it's just not looked at with males at all. From what I've seen. It's not in the media, it's not in ... you know... it's not in the forefront. It's still hard to find stuff, so..."

Increasing awareness of eating disorders in males as a minority group may be compared to the information strategies of gay rights organizations. Written and oral information is aimed at increasing the understanding and tolerance of gays within the heterosexual population to reduce discrimination against them. Gay men involved in various organizations have found that they need to join together to defend and further their rights and status in society. The information strategies seeks to do two different things: to "normalize" homosexuality while at the same time to distinguish it (Schedler, 1996). The information strategies of homosexual male organizations, then, may provide an example for addressing the issue of males with eating disorders.

Several specific suggestions for increasing awareness of individuals that can be affected involved pictures and posters that showed a variety of people, weights, body shapes and sizes.

♂: "Why can't you show a picture of a guy saying, "This person is anorexic." An individual that looks like the regular everyday average-day Joe. Or put 5 guys on there who look very diverse and they could come from anywhere. And say, "All these guys..." or say "Pick out the anorexic one. Pick out the bulimic one." And then the inside of it would say, "They're all bulimic. They're all anorexic."

♂: "It's like.. um, well we have the same sort of aspect in a.. in our.. gay awareness, some of our gay awareness posters. It's like, there's a group of guys on the.. on a sheet and stuff. And they're all different looks and stuff, and everything. And it's like 'Which one of us is gay?'"

2. Written Resources

♂: “..... you’ll always see eating disorder pamphlets in the doctor’s office. Anorexia, bulimia. But it’s geared towards women. You know, if there was also.. if that same pamphlet was either gender neutral or there was one right beside it for males.....”

Most of the discussion that the men had about written resources related to access and location, as well as format and design. Language (‘she’ vs ‘he’) and topics covered may need to be directly related to men with eating disorders in order for them to relate to the information. Having written resources that will appeal to men and that will be noticed by them was seen as important.

♂: “..... but when I’m sitting on the doctor’s table..... waiting for the doctor to come in for the examination I’m always reading just titles, you know. And if it said “Men and Bulimia”, or something like that. And... and I was a bulimic male that was sitting there, and I saw that, I mean chances are that I’m going to pick that up and throw it in my pocket. Or, you know, throw it in my jacket. Even if I don’t want the doctor to see me grab it I mean, there’s still that 10 minute wait that you’re sitting there, where you can have access to it.”

The “tone” of the information that is contained in written resources - “scary titles” like “anorexia” and “bulimia” - may make men hesitate to pick up the information.

♂: “A lot of things is, um... sort of trying to steer away from the big titles. Like, don’t put on it in big titles ‘anorexia’... in straight men or gay men. Sort of stay away from the big, scary titles. So maybe have that in smaller print, underneath, like, ‘eating disorders’, or ‘what’s your body image?’ sort of thing.”

Official labeling of a disease may reinforce. Stigma has enduring effects that remain with a person after treatment. The questions are if the effect of stigma endures because rejection by others continues or is it difficult for the person to shake off the stigma of a mental illness even with a medical diagnosis. The challenge of health care providers is to address stigma in its own right to maintain the benefits of treatment. Research has indicated

that stigma affects depression even in the presence of effective treatment interventions (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997).

Some other suggestions that were given related to written information, as discussed in the sections “Format and Design”, “Focus”, and “Access and Location” included the following:

- information that is quick and easy, that can be taken home and read in private
- using written resources as an opportunity to direct people to more specific treatment or education
- target media as an avenue for awareness
- neutral presentation, where the design will appeal to both men and women
- focus on those groups that are most vulnerable to body image problems and eating disorders
- making eating disorders education part of the curriculum
- have information on education and treatment available in hospitals, doctor’s offices, community organizations, libraries, fitness centres, and schools

3. Support and Communication

♂: “Eating disorders.... um..... I love for there... I’d love for something to be started like AA or something where you can go and check yourself in and talk about it.”

There were a few suggestions about support resources that could be developed for men with eating disorders. Further to the section on “Personal and Community Support,” the suggestions of a “buddy system” for eating disorders was mentioned. As well, developing groups that would address healthy eating and dieting behaviors were noted. One man suggested a group check the adequacy of your diet and to learn about healthy eating.

♂: “I would definitely go to something like that. Like if there was a group where you’d go and you’d check yourself in and.. and you just go over what you ate with someone over the past week.

The idea of an AA-like or 12-step program was noted by participants. This was thought to help with coping and feelings of isolation. Eating disorders are thought to be linked to addictions from a psychological perspective (Riley, 1991). Riley (1991) discussed

the use of 12-step programs with eating disorders, suggesting that they can be integrated into an overall program for eating disorders.

Another form of support resource that was mentioned by a few of the men was the idea of an “eating disorders hotline” where people suffering could call and get information and talk to someone. For the men, this was thought to be especially helpful because it could be totally anonymous and unthreatening.

♂: “Mmm, hmm. Yeah..... Um... just eating disorders hotline or information number that people would call and “If you want information about this, press 1”. And you could just.. um... even if it didn’t need to be manned, and a person could request that something be sent to them.”

The idea of phone-in peer counseling was discussed. In some community organizations, there are 24-hour crisis lines or hotlines where people can call. Staff of the organization are trained in peer counseling and communication skills and are available to give information and support. The function of the hotline would be to give resources (people to call, educational material) and to listen and encourage callers to talk about their concerns. This allows that caller to open up and get to the real issues behind the call, reducing feelings of isolation and hopelessness.

4. Media

♂: “..... But maybe if we put bulimic guys on a TV show, other guys will identify with them and say hey, I’m bulimic.”

Media was discussed by the men as a resource in itself for awareness and education. Because various types of media are widespread and their messages have a “far reach,” participants thought that a large number of people could be reached with media education about eating disorders. There was an interesting analogy made about how media could bring acceptance to eating disorders by comparing it to the issue of sexuality in the media.

♂: “Just like.. um...the whole sexual orientation thing. Nobody was really accepting. Now you have Ellen on TV, the first female character. And you had Matt on Melrose Place, the first .. um.. prime time gay guy since Billy Crystal on Soap, you know. And it’s become more... people understand more about it and it’s becoming more accepted and people are willing to deal with these issues and talk about them and think about them. And with bulimia, you don’t really see that still..... Nobody knows about it because nobody tolerates talk... talking about it.”

Some of the ideas included having characters on major television shows experience an eating disorder. Soap operas, prime time dramas, children’s shows, TV news magazines, and even sitcoms were mentioned as good examples where the lives of characters could have lessons for the viewers of those shows. Research has supported the effect of media as a possible contributor to decrease in eating disorder symptoms. Media resources used to increase awareness of the potential consequences of fasting, bingeing, and purging may act to discourage unhealthy eating practices; as well, examples of celebrities and individuals nearly dying from eating disorders has been suggested as effective (Heatherton, Nichols, Mahamedi, & Keel, 1995).

Another form of media that was discussed was that of printed media. Magazines, for example, because of their wide reach, were suggested as a good avenue for eating disorders information. This information could be in the form of articles about eating disorders or advertisements for services. One of the men who is a homosexual suggested using gay specific media for education about eating disorders in men.

4.3.9.2 Suggestions from the Health Professionals

The health professionals had several suggestions for treatment and information resources that males with eating disorders might find useful in dealing with their eating problems and for resources that would help health professionals to be better equipped to help males with AN or BN. Their suggestions focused on adapting resources, written resources, promoting resources and information, and support and communication.

1. Adapting Resources

HP: “So then if.. you sort of say you don’t need to reinvent the wheel, you just need to perhaps make that information just more generic...”

Because of the relatively large availability of female oriented treatment and information resources, several health professionals discussed the adaptation of already existing resources for use with males. They noted that many of the resources that are available for females are easily adapted - 12-step treatment programs, counseling services, support groups, and general information about eating disorders. However, the issue of influencing factors on the eating disorder was brought up - some felt that the issues would be the same for males and females, and some felt that they would be different. Related to adapting resources, participants noted that the influencing factors on the male’s eating disorder must be considered.

HP: “I mean I think it’s.. it’s good to adapt female resources for males, but you have to be very cautious and sensitive about... the other half of the point, you know.”

When adapting educational resources that professionals might use to address body image and eating disorders with groups of males, the language of the information was discussed. Some felt that the feminine language of many teaching resources would need to be adapted to suit the group being presented to.

HP: “Trying to take a female resource, because it was very female oriented, and tried to make it applicable for both males and females. And even as you’re going through the manual, and taking out certain philosophies - it’s all written ‘she’, ‘she’, ‘she’, ‘she’, ‘she’, you know - we have to, sort of, change it around and put, you know, ‘one’s expectations are’ and ‘one’s views themselves’, you know.”

Part of adapting resources for use with males would be to make the resource more applicable to males, and to allow them to identify better with the information. Making the design of resource more “gender neutral” rather than with “bears and flowers and birds and

things” was thought to be one way. As well, incorporating body and self-image topics that are specific to males might help them relate to the information.

2. Written Resources

HP: “So what we really need, I think is to start with something really basic. Just being able to promote that there’s help available. And then have as many resources as possible, like we do for females, except that they’re not just for females.”

Much of what the health professionals had to say about written resources was discussed in the sections on “Format and Design,” “Focus,” and “Access and Location.” The main issue was having male specific information to increase awareness of the topic of eating disorders in males, and communicating their availability to males. One of the specific suggestions was to have posters showing the “male side of things.” As well, newsletters and pamphlets on males with eating disorders were mentioned. One suggestion was that it would be good to have fact sheets to give to male clients that they can take home with them for information. Another was that submitting information to provincial eating disorders newsletters would be a good place to start.

Other suggestions that were given related to written information, as discussed in the sections “Format and Design”, “Focus”, and “Access and Location” included the following:

- anonymous resources that are readily available and can be read in private
- educating professionals to deal with male clients with anorexia and bulimia
- have literature available in schools, health care facilities
- use media for education and awareness
- neutral design and presentation
- have male specific facts available

3. Avenues for Promotion of Resources and Information

HP: “.... what we should do is..... be more.. more vocal with... the groups that are preparing resources now. So as they do more newsletters or they do more bulletins that..... they are conscious of making them.. neutral.”

The role of professional advocacy for addressing the issue of males with eating

disorders was mentioned. Professional committees addressing eating disorders resources and education were noted as a potential initiating force.

HP: “..... they could write a letter on behalf of the committee. But then also each individual who’s on the committee could take it upon themselves to do that.. that contact as well. I think there’s a lot of strength in numbers.”

Professionals coming together to address the issue of eating disorders in males was noted as a positive step towards resource development. Education activities during “Eating Disorders Awareness Week” (1st week of February) each year was one suggestion. Another suggestion was knowing a male nutritionist to help address some of the issues.

The media was seen as an avenue for promoting both the issue of males with eating disorders as well as specific information about the topic. The health professionals also discussed television as a good way to communicate to men and the general public, such as shows or movies that have a character with an eating disorder. Printed media such as magazine and newspaper articles specific to males and eating disorders were noted as valuable. Gay specific media was also mentioned by one of the health professionals as a good avenue to target a high risk group of males.

4. Support and Communication

HP: “Actually D and I were talking about that today.. um.. how that even having support group that is facilitated by a male maybe not someone who’s had an eating disorder, but someone who has the knowledge and he can also work with things like self-esteem.”

The health professionals did discuss resources for support for males with eating disorders. Relating to support groups, the main issue that was mentioned was that it would be doubtful that there would be sufficient numbers to have an all male group. But they did mention that the existence of support groups that males might be involved in needs to be communicated.

One suggestion from the health professionals was a crisis phone line that men could call to get help for their eating disorder. The benefits that were noted were anonymity and safety. It was thought that this service would decrease feelings of isolation and help men get the resources and help they need.

Another suggestion was that the men themselves need to be vocal to organizations about their experiences and observations. It was thought that this, in combination with professional input, would be useful.

Media coverage, displays, and information were mentioned as ways to promote the issue of males with eating disorders.

4.4 Barriers Related to Resource Access and Use

There seemed to be a number of issues that affected the males' knowledge of and use of both information and treatment resources for their eating disorder. Both the health professionals and the male eating disorder participants identified that these barriers may inhibit males from adequately dealing with their eating disorder. The main themes around barriers that arose consistently during participant interviews will be the focus of the results reported here. Specifically, the major barriers that were identified include problems with recognition of the eating disorder, seeing eating disorders as a "female disease", males living up to a "strong man" image, and a sense of isolation. The barriers discussed here are based on input received during participant interviews and not on inference by the researcher.

4.4.1 Recognition of the Eating Disorder

HP: "It's harder for them because nobody really looks for it. Nobody asks. They can hide it a lot more easily than if a woman is not eating or, you know, she's picking at her food or things."

Both the health professional participants and the male eating disorder participants discussed the failure of health professionals, family, friends, and others to recognize the signs of an eating disorder as a barrier related to resource access and use. Because eating disorders

are seen mostly as affecting females, both the men and the health professionals thought that many men may not be offered services for addressing their eating disorder because others don't recognize the eating disorder soon enough.

4.4.1.1 Recognition by Friends and Family

Some of the men felt that friends and family would not have been able to detect the signs that a problem was occurring.

♂: "..... I know in my case, there... nobody could have looked at me and said, you know, ok, this is going to be a concern. I see that there's going to be a bulimic episode coming up here. And.. uh.. so what are we going to do now to try and stop this before it ever happens. You know, nobody... I didn't even know it was going to happen. And I... I... I'm pretty sure nobody else would have known."

Several of the men experienced lack of support from family related to their eating disorder. Participants who were gay noted that "coming out of the closet" and admitting to an eating disorder was extremely difficult; they often did not receive support for either issue.

Many of the men expressed that no one brought up their eating behaviors until they were very sick.

♂: "I just think that I was sick, you know (chuckle). Malnutrition and... I was, like, ready to die. And... uh... that was when they said 'You know, I think you might have an eating problem.'"

Participants expressed that it motivated them to seek out resources and ways of addressing their problems when someone brought up their concerns about their eating disorder. Often, self-motivation to seek out information when the eating disorder began was low, especially when they did not perceive support from others. The men expressed that they would be more likely to seek out resources when others took an interest in their eating problems.

♂: "Like I'm not even... I'm sure my parents... you know, saw the change and stuff when they came to visit but..... they never said anything..... They never voiced any, um, any concerns... towards it so.... I didn't really have that aspect either.... I's like I'm sure that also if my parents had said

something, then I'm sure I would have done something..... it probably would have opened my eyes..... to make me more aware.....
When you... like when it's yourself and no one really wakes you up to it, you don't really notice it. Cause you know, you see yourself in the mirror everyday, and you don't notice the changes unless, like... someone says something or something just..sort of change your mind's aspect. And you look in the mirror and it's like, what am I doing?"

♂: "..... so if someone doesn't eat... "Why aren't you eating?" You know, like, you hear... I needed somebody to catch it so that when you deal with these issues, someone that... you possibly can work through. "

The men had not received many suggestions from friends or family about resources to consult and help them with their eating disorder. Much of the information, books, articles, etc... that the men had read were found through their own searches. When they got to the point where they wanted information, they found it on their own.

The health professionals agreed that family and friends may not be quick to recognize an eating disorder in a male compared to a female. They noted that often people who are close to those suffering an eating disorder may not realize the seriousness of the condition. A few of the professionals noted that one reason an eating problem may not be noticed as easily in a male is because it is more well known in females.

HP: "I wonder if in males we would, whereas if we saw a female similar, we would automatically think eating disorder because it's, you know, more highly profiled. Whereas with a male, we might.. you know, I would probably, you know.. might think something else."

Failure to recognize the signs may be related to the type of eating disorder occurring. The extreme weight loss caused by self-starvation in anorexia attracts the attention of family and others moreso than the private bingeing and purging behaviors of bulimics (Carlat, Camargo, & Herzog, 1997). It was noted that there may be a delay between the time that an eating disorder starts to when the males are ready to seek help for it. Failure of others to recognize the signs of an eating disorder may affect this delay in getting help.

4.4.1.2 Recognition by Health Professionals

HP: "I think it's definitely something that you.. one has to keep in mind and consider. It's not very common. Um.. it's not as common as it is with women. And perhaps it is one of those .. I think there are many that are neglected or looked over because they're not... they may not be as easily identified."

Both the men and the health professionals discussed the lack of recognition and knowledge about eating disorders in males as a barrier to obtaining services and resources. The men noted that it is hard to find out what professional treatment resources were available for them.

♂: "I wouldn't know where to go, even... it's even hard to get a psychologist or someone to, you know, like tell you where to go because they don't... See, if I went to a doctor that's probably what would happen. They'd say, 'There's nothing wrong with you.'"

Some of the men recounted their experiences in seeking medical help for their eating disorder (or related psychiatric and physical problems). Among their experiences included a psychiatrist who did not recognize the eating disorder even when the man told him about his dieting behaviors, and a doctor who never questioned bulimia when the man had constant throat problems. When professionals are not recognizing an eating disorder, the men discussed that they get better at "hiding" their condition.

♂: "You know, I mean this person's dying here... um... probably a person who's bulimic is going to be... appear to be healthier. I mean their enamel may be wearing off their teeth, or they may be sick... um... but... it's not as obvious. So... and you... get good at hiding it. It's amazing. Nobody knew. If they did, they sure never told me. Any body I did tell never said, 'You know I really wondered. I was wondering about that'. Never."

Research has suggested that physicians may be unaware of an eating disorder in males and may concentrate their investigation on more remote causes of weight loss (Andersen & Mickalide, 1983). It is important that clinicians not pre-maturely dismiss the possibility of an unusual diagnosis to explain weight loss, such as anorexia in a male patient. A case study

report indicated that one man's struggle with an eating disorder went unnoticed for two years even though he was under psychiatric care (Black & Cadoret, 1984).

The health professionals agreed that in some cases, eating disorders in males go undiagnosed and unidentified for a longer period of time than in females. Lack of familiarity with AN in males has been noted to lead to delay in evaluation, diagnosis, and treatment (Siegel et. al., 1995). The long delay before referral to specialist services to deal with the eating disorder may be the result of resistance to treatment on the part of the males, and also the lesser degree of public and medical alertness to the condition in males (Margo, 1987; Touyz, Kopec-Schrader, & Beaumont, 1993). The longer a delay, the more likely a poor prognosis (Touyz, Kopec-Schrader, & Beaumont, 1993). Male patients themselves may not bring up concerns about eating. For example, one comment related to the males hiding their eating problems.

HP: "I think that just because we don't look for it. It may not.. maybe they don't want to hide it. But we don't notice it, so then it goes unnoticed for a lot longer."

The health professionals felt that part of the reason eating disorders may go unidentified in males is because there are very few professionals who have had experience with male eating disordered clients. Because most do not see males with anorexia or bulimia on a regular basis, they may not be as likely to think of an eating disorder in a man. Lack of awareness by professionals that eating disorders occur in men and about the issues that affect males related to their body may contribute to why eating disorders in males are missed. By focusing only on the females, several health professionals felt that it makes it difficult for men to come forward for help and resources.

HP: "..... we probably wouldn't maybe have taken the time to consider the fact that we are mainly focusing totally on the females. And ostracizing the males more and more, making it more difficult for them to come forward. Not intentionally, but just because we hadn't thought about

it. And I think that.. that's what's happening..... with the health care providers. We've been so programmed and so indoctrinated and convinced this is a female condition that.. that's their total way of thinking.”

The lack of recognition of an eating disorder in males by health professionals is supported by the studies of several researchers (Andersen & Mickalide, 1983; Schneider & Agras, 1987; Touyz, Kopec-Schrader, & Beaumont, 1993). Reasons cited include difficulty of diagnosis of eating disorders in males, lack of knowledge about AN and BN in males, and relying on observations of females with eating disorders.

4.4.1.3 Recognition by Men Themselves

♂: “I think myself. I think I don't.. like... I don't see myself like that, so why label it for the help.”

Both the men and the health professionals felt that part of the reason why males with anorexia and bulimia do not know about or do not seek treatment and information resources is because they do not recognize that they are having eating problems. The men often did not realize that the dieting and/or purging behaviors they were practicing were an actual eating disorder. One man referred to it simply as “just something that I did,” and because nobody knew, it was not addressed. Another expressed that he felt that the purging behaviors were logical.

♂: “I knew there was a problem, but I thought it was... I thought it was normal. If you didn't want to do it, this is what you do..... It's like, if you don't want your teeth to decay, you brush your teeth. You know, if you don't want to get fat, you just throw up the food after you eat, that's all.”

Some of the men expressed that when the eating disorder becomes a compulsion, it is difficult to consciously recognize the danger of their behavior.

♂: “Yeah. Because that’s all... it’s mind games. Cause you know logically what you’re doing is hurting yourself. But you look in the mirror and see this fat person. And... and it’s not even you anymore. And you know that. It’s just... but, you know.. you’re heart and soul are saying one thing and your mind is saying something else. And the mind tends to always win.”

♂: “I didn’t even think about it. It didn’t even cross my mind that it was unhealthy.”

The men expressed that it may not be until they are seriously ill that they recognize a problem.

♂: “I’m rather hesitant about.... seeking medical attention. Just cause usually I think, like, I can take care of this myself. I will deal with it..... Unless I’m virtually dying, like on my death bed sort of thing.....”

This hesitation indicates that the men may not recognize the early signs of an eating disorder in themselves. Recognizing what is happening and knowing you have a problem were noted as the first steps to getting help for an eating disorder.

♂: “You know, not until I realized that it was um.. it was being harmful to me would I.... would I stop and think ok..... What am I doing? Why am I doing this? I know it’s bad for me now, you know, after say, four or five months, I know this is now bad for me. But why am I doing it and what can I do to stop it.”

The men expressed that when the behaviors are being practiced, they may not think that the label of an “eating disorder” can be placed on what they are doing. Men themselves may think that eating disorders are “something that only girls go through. Like men don’t have these problems.”

♂: “Sort of ‘Well, it can’t really be happening to me. It can’t be really what it is. It just.. you know, I just don’t feel hungry for this week’..... Oh no, that’s a girl’s thing. That can’t happen to a guy.. to a man (in a deep, sarcastic voice).”

The assumption by men themselves that they are not vulnerable to eating disorders has been related to the prevailing view in the media that the disorder occurs only in adolescent females

(Andersen & Mickalide, 1983).

The health professionals agreed that many men with disordered eating do not recognize it as a labelled “eating disorder.” Some of the professionals had had male patients who were practicing dieting and purging behaviors, but who never sought help for them because they did not recognize a problem.

HP: “Yeah..... And so I don’t.. I don’t think that they would.. they would recognize it. And if they did recognize it, I think it would be very difficult for them to come forth and say, you know, ‘I have an eating disorder. I need help.’”

One idea that was mentioned was that if the resources were more applicable to males, then they might recognize that their eating behaviors are putting them at risk of an eating disorder.

HP: “And it’s harder to, I think, connect with some of the.. speaking more.. not all the resources, but the written resources if that.. um.. if it’s easier for them to identify that, you know, this can be happening to them, not... you know.. just a “woman’s problem”. It could be very similar to that.. that man. He didn’t recognize that he.. had an eating disorder which, I bet you, he heard about eating disorders in females millions of times. but he just never made the connection that.. it could happen to a guy and what he did was mimic that behavior.”

The health professionals discussed that men may find it difficult to see themselves as having an eating disorder. They also expressed that it may be harder for men to recognize that there is a problem because they have not been educated themselves that eating disorders happen in males; they may not make a connection to the problem, and therefore not seek help or information resources.

HP: “So... (xxx) men think that they have concerns about eating, they’ll read that and say, “Well, that must not be me. I can’t be in that 1% or 5% of the population. I must have something else.” They just can’t.. um ... shut it off and carry on with life.”

Denial and “male ego” were noted as factors that might prevent men from recognizing disordered eating as a problem in themselves. Both the health professionals and the men felt

that communicating the availability of resources and general awareness that eating disorders happen in males could help counteract this lack of self-recognition.

4.4.2 The “Female Disease”

♂: “‘I have a woman’s problem.’ That’s where the problem comes in.”

Both the health professionals and the men identified that a major barrier for men in dealing with an eating disorder is the perception that anorexia and bulimia are a “female disease” or a “woman’s problem.” Both groups identified this perception as a major stigma attached to eating disorders - men who are experiencing anorexia or bulimia may be hesitant to express what is going on or seek treatment and information for fear of being associated with this stigma. This is supported by the research of Schneider and Agras (1987) which suggested that males may be embarrassed to admit to have an eating disorder. Fichter and Daser (1987) also suggested that males may be less likely to seek help for an eating disorder than females.

Sexual conflict in eating disorders may be magnified by the “female disease” perception. A “constellation” of sexual difficulties was identified among 27 males with AN or BN; these difficulties included sexual isolation, inactivity, and conflicted homosexuality, all of which may complicate eating disorders in men. The reluctance of males with eating disorders to seek help for a stereotypically female problem may be compounded by shame or anxiety in acknowledging these sexual difficulties to a professional (Herzog et. al., 1984).

The fact that many written resources are female oriented and written in the feminine sense was identified as contributing to this stigma. Both groups discussed that general information about eating disorders and awareness materials were focused on women with anorexia and bulimia. This was said to contribute to men’s hesitation to request information on eating disorders as it may apply to them. Sometimes the content of the information perpetuates the stigma.

♂: “..... I remember the first time I heard about eating disorders it’s like PMS and eating disorders both seemed to be identified around the same time, you know. And they made a point of saying that most people who have eating disorders are 90, 95% women. And I knew that 100 % of the people who have PMS are women..... you know, being a 14 year old, 15 year old or whatever I was at the time I certainly didn’t want to be associated with a women’s problem..... “

Receiving and reading materials that discuss women with eating disorders were said to help the men by giving general information; however, female information may make men hesitant to talk to other people about it “because of that preconceived notion” that eating disorders only occur in women. Feelings of shame and embarrassment may be felt when men express that they are having eating problems.

♂: “Yeah, well that’s because when I had talked to her... uh, at first, I said that, you know, it was really embarrassing because this is a so called... uh.. woman’s disease. You know, and.. or disorder. And... and here I was, you know, battling with it. And I felt really uncomfortable talking to other people about it.”

Several of the men felt that the focus on body image, thinness, and beauty in eating disorders awareness perpetuates the notion of a “female disease.” The general feeling is that resources should promote that anorexia and bulimia are eating disorders, not “a woman’s disorder.”

♂: “I think that people probably just don’t think that guys do have... eating disorders... You know, they think..... it’s not a guy thing. It’s a girl thing. Girls are into their images and self appearances. And their self images and self-esteem are based on ... on their personal image. It’s not.. where guys are based on their personality, their ability to participate in sports, their social status, you know.”

♂: “..... it’s not understood and therefore.. um... because people are like “Well, why would a man have an eating disorder?” It’s perfectly acceptable for men to have a beer belly. And people who are... people don’t really look down on that man for having a beer belly. You know, or for big guys, you know... they’re not... looked down upon. So I don’t think people understand that..... that, um... that it is ok for men to have

eating disorders. Because you know, men have minds too and it's... it's a mind thing. And emotions and feelings.”

Some of the health professionals felt that the more it is said that 90-95% of eating disorders occur in females, the less likely it will be that males will come forward and get help for their eating disorder. There was the feeling that eating disorders have “just been stereotyped so much towards the female,” so most men won't want to be affiliated with it. Another feeling was that because much of the research on eating disorders has been done with women, it may be that no one has ever asked males if they engage in those behaviors. From a professional point of view, the stigma of having a “female disease” may cause men to be even more secretive about their eating disorder.

HP: “And especially since eating disorders is seen as a female.... condition, it's even more secretive for men. I don't know how you bring them out... as a counselor.”

A few of the professionals proposed that the lack of male specific resources was a reflection of very few males coming forward with eating disorders; further to this, they expressed that very few males may be coming forward with eating disorders because it is seen as a “female disease.”

4.4.3 The “Strong Man” Bluff

♂: “I think it just kind of comes down to the “man in control” thing.”

One of the most frequently and strongly talked about barriers that the health professionals and the men identified was the need to maintain the “strong man” image - that nothing can hurt men, that they are not emotional, and that they can handle all problems without help. As well, that the last problem they might have is with eating and food.

Participants expressed feeling the need to live up to an unbreakable image for men set by society. They felt that eating disorders are difficult for everyone to have to deal with, but that women may be less stigmatized or looked down upon than men - that it is less socially

acceptable for men to seek help for mental or psychological issues.

♂: “Yeah. It’s ok for a.. it’s ok, be socially acceptable, for a woman to say, ‘Hey, I have a problem. I’m going to go and get help. And there’s this social support network that’s going to help me maintain myself while I’m seeking help’, you know. Men are, ‘I’m a man. I have a girlfriend. I have a family. Or I have... blah blah blah. And I have these obligations to them and if I show that I’m weak, then I’m.. not going to be able to.. I’ll get weak. I’ll be seen as somebody who is weak. And I won’t be able to hold my role in society.’”

The men felt that it would probably be easier for women to express problems with eating disorders because there has been more awareness about the issue in females.

♂: “My instinct would tell me that women have an easier time talking about these kind of issues. So I think it would be easier for them to access these kinds of resources. Because it is acknowledged that a lot of young girls are pressured, you know, because of Barbie and all these mass media images which are... are... accessible to people. But you don’t really hear about men’s issues like that.”

In reflecting upon their role as a man in dealing with emotional issues, they perceived that they were expected to be strong and unemotional, to “suck it up, get it done”, with no room for emotional tie-ups. They expressed not wanting to appear “weak”, “vulnerable”, “humiliated”, “feminine”, and “weird.” Some of the men expressed actually feeling weak when practising the eating disorder, and not wanting anyone to know about it.

♂: “... it’s the weakness aspect of it, my mind. I feel weak when I do it. You know, this is somebody that can’t manage. And for me to admit that, I do it and... and it’ll get back to the job place and then I’m out of a job. Um... the whole concept of just being weak, and that just feeds off itself.”

Participants expressed that it is harder for them to go to a counselor to talk about their problems “because it reflects on their machoism,” and are more likely to deal with problems in other ways. One man expressed that men are “not taught to deal with our problems cause it shows that we’re weaker and that we’re less than what’s expected of us.” Male patients may be embarrassed to report their symptoms, allowing the eating disorder to remain

undiagnosed (Andersen & Mickalide, 1983). Men may not want to admit to others and to themselves that they need help and that they have a problem.

♂: “Nobody wants to admit they have a problem. Every... guys want to say, ‘Oh, I’ve got my life under control. I, you know, I do everything on my own. I’m independent”, blah blah blah blah. It’s that fear of disclosure and being ashamed that you do have a problem and that you don’t have the perfect little life and you’re not in control.”

The “strong man” image was expressed as one of the reasons men may not seek treatment or information to help them deal with their eating disorder. They feared that “some people will just sort of view it as a weakness”, and that the societal expectations “make (them) really hesitant to, like, sit there and admit that (they have) a problem.” It has been suggested that males are less likely to seek treatment for an eating disorder than females; the lower incidence of males with eating disorders may partially be an indication of this hesitation (Mitchell & Goff, 1984; Carlat & Camargo, 1991). Levels of social desirability and masculinity have strong links to eating disorder symptoms (Johnson, Brems, & Fischer, 1996). Participants noted that the hesitation to express feelings and problems related to anything is part of their upbringing and is influenced by family and social interactions.

♂: “It’s because we’re brought up with the whole “macho” image. For men, it’s strong. It doesn’t really reveal anything. It just kind of gets handed down.”

♂: “... I think a lot of men sort of seem to feel that.. um.. if they have an eating disorder or something, that it’s a weakness..... And..... like, it’s the way men are pretty well raised is that they have to be strong, emotionally strong. Like human rocks. Like nothing will stir them, nothing will shake them down..... We have to be able to just sit there and take whatever. So... that’s... for a man to show that he has a weakness, it’s sort of a social taboo.”

Some of the issues that are associated with anorexia and bulimia may also contribute to men’s hesitation to admit there is a problem and seek help. For example, admitting to low

self-esteem and distorted body image goes against the expectations of what men are supposed to feel and think about.

♂: “..... Men if you don’t have a very strong sense of self-esteem or if you don’t.. if you don’t come across as very confident, then something’s wrong with you, you know, people give you a weird look, you know.”

The men agreed that being comfortable with how you look is not true for all men, and that more and more, men are becoming conscious of their appearance and their weight, which goes against this “strong man” image. However, men may hesitate to ask for help for these issues because “you’re always worried about the disclosing and the shame and not... holding into norms and all these little obligations that are bestowed upon you as a male.”

The health professionals also discussed the same expectations of a man’s role in society and how that affects the way he might deal with an eating disorder. They also discussed that men may hesitate to seek treatment or information to deal with their eating disorder. Men may feel that eating disorders would be seen as a weakness, and were less likely to admit to it and ask for help because of the “macho image.” They felt that it was more difficult for a male than a female to admit to an eating disorder; there is the possibility that “... there are really a lot of males.. individuals that have really serious eating difficulties that we are missing.” One of the professionals drew an interesting analogy with other physical illnesses such as cardiovascular disease and diabetes. They wondered “... do males perceive illness as weakness and failure?” and they may see it as an intrusion on their life.

HP: “... certainly with the business of heart disease, too, I have run across men who are just totally pissed off because they don’t have time for it. And it sort of like, how could this happen to them? How dare life hand them this?, you know. And.. especially in the initial stages, so maybe that has to do with shock and, sort of, denial.”

Men may initially deal with health problems through denial, feeling that “If I don’t acknowledge it, it won’t be there.” However, “that pride and ego thing” may further prevent

them from addressing their eating disorder.

The health professionals discussed the societal view of a man's role. They agreed that part of this "image" is that it is not "ok" for men to "feel" and have emotions. With adolescents, for example, it may be that "it's not cool for guys to talk about their feelings." They identified a major barrier to expressing problems and showing emotion as being the "strong man" image.

HP: "Oh, dear society, you know. Boys aren't supposed to cry (sarcasm). There's still.. I think it's getting a bit better, but there's still.. you know, this... um.. sort of stereotype with what a 'man' should be. If you're going to be a man, you know, gotta be strong and... be in charge and.. there's still a lot of that. And.. and guys really... tend to think of themselves as wimps and wooses and.. and everything.. if they can't pull it all together like that. And if they can't pull it all together and they can't feel comfortable talking about it, they're extremely vulnerable for all sorts of things."

When addressing issues related to males and eating disorders, the anxieties that boys or men might "fear" may not be directly related to their weight or appearance, but more to how they fit or do not fit with society's expectations. For example, boys may fear being "wimpy", "scrawny", or "weak"; "stupid" and "ugly" might also fit for them. Because boys are supposed to want to look "big" and like "strong, dominant leaders," they may hesitate to express feeling "fat" or concerned about their appearance. However, a number of health professionals did describe that males do want to be attractive and do worry about their appearance.

HP: "I think certainly boys.. want to be attractive to females as well.. in the adolescent years. Just the way.. the same as the opposite. And um... uh.. they also want to have the male... perception of being the.. you know, kind of the "male hunk" type of thing. Um, you know, the muscular.. strong (chuckle). And um.. so it doesn't necessarily just have to be for sports. I think they want to... you know, it's the male image."

Males may want to be perfect or may strive for a certain image, but will not admit to what

they do to attain it.

4.4.4 Isolation

♂: “I think so because.. when you’re isolated, then you don’t feel as though there are any resources out there. You think, ‘Well why would there be anything if I’m the only person’, right.”

Both the men and the health professionals expressed that feelings of isolation by men with anorexia and bulimia may affect both their knowledge of and access to information and treatment resources. Lack of communication and feelings of isolation were noted by the men as prominent difficulties.

Some of the men who are gay expressed that feelings of isolation of being a man with an eating disorder were analogous to feelings of isolation associated with being homosexual. Feeling like you’re “part of the bigger picture” was mentioned as decreasing feelings of isolation.

♂: “As a stigmatized individual, realizing that there are other stigmatized individuals like them with the same stigma. And.. they can survive in mainstream society... and try to become healthy.”

Homosexuality may act as a psychological stressor in male adolescents and in this way predispose them to bulimia (Carlat & Camargo, 1991).

Having connections with others experiencing the same issues and knowing that you’re part of a “group” of some sort were noted as helping the men not feel so isolated. Communicating that eating disorders do happen in males was mentioned as being necessary to decrease feelings of isolation, which would encourage men to seek information and treatment for their eating disorder.

♂: “I think they would realize that they’re not the only person, and they’re.. they’re not the only person, there must be somebody else. If there’s somebody else, then maybe that other person found a way to deal with it. If somebody found a way to deal with it, then it’s.. there’s got to be something out there to help them deal with it.”

Feeling alone and isolated were discussed as being reasons why “you don’t really want to tell anybody that you have this thing.” Feeling “alienated”, “isolated”, “alone”, “separated”, and like “the only one” were noted as reasons for not accessing treatment and information resources.

The health professionals also discussed the “secretiveness” of eating disorders, both in women and in men. They thought that because anorexia and bulimia are so secretive in women, it must be much more so for men. They noted that not knowing how they can come out of the eating disorder successfully contributes to the sense of isolation that a man with anorexia or bulimia might feel.

HP: “So it really can be a sense of.. hopelessness. And ‘What’s the difference anyway. It’s always going to be like this.’ Becoming more and more isolated.”

4.5 Results from the Feedback Process

Both the health professionals and the male eating disorder participants were given the opportunity to offer feedback relating to their participation in this research. Overall, the information received through feedback did not differ greatly from the results of the primary interviews. There was no feedback received from the health professionals in response to the summary notes they received from each of their interviews. There were no corrections made, and there was no additional information formally offered as part of the research.

For the male eating disorder participants, there was also no feedback received from those men who received the feedback report through the mail and who declined a second interview. Three out of the eight men did agree to a second interview for feedback purposes. During this interview, the major themes from the primary interviews were explored, and the men were asked for additional input and clarification. Overall, the information received through the three feedback interviews was consistent with the results from the first interviews. The results reported thus far have included information and quotes from both the

primary interviews and the feedback interviews (where the issues explored were the same); most input from participants during feedback was confirming the results from the initial interviews.

There were a few additional points that were brought out during the feedback interviews. They were in elaboration of the major themes that arose during the first set of interviews, but were original/additional ideas. They are related to Format and Design, Gender Specificity, and Nutrition Information.

4.5.1 Format and Design

Some of the men discussed that there are differences in written information. Some provide more detail and discussion, while some provide facts.

♂: “And any sort of, you know.. you can read in your spare time or whatever. When you’re riding on the bus, whatever.”

♂: “Mmm.... well that can depend on what.. like what’s the form that it’s in. Like if it’s a pamphlet, then it’s more quick and easy. But if it’s books or.. or entire packages then, you know, you get more specific.”

Pamphlets stimulated much discussion as a familiar resource to the men. There were a number of comments that pamphlets and written information are best used as an introductory step, providing a “foot in the door” approach. One suggestion was that pamphlets could provide information on people and places to contact for more specific information on getting treatment, support, or more general information.

♂: “Like using the pamphlet as more of a first step.”

♂: Mmm, hmm. Cause like, even with the pamphlets you can have.. make references to packages and books.

4.5.2 Gender Specificity

There was a suggestion that males with eating disorders are using the “female” resources that exist now. There were thoughts that there may be a greater demand for male

specific resources than is known. Men may just grab the first piece of information they come to without asking for male specific information. If men are using women's eating disorders resources, one suggestion was that it may look like more women's resources are being demanded than actually being used. In other words, there may be a greater demand for male specific resources than we recognize.

♂: "You know, and if there's... people keep grabbing the either non-gender specific or ones aimed more towards females, it's going to seem like there's a higher demand for it (*than male resources*)."

♂: "Just cause, you know, there hasn't really been... gender specific information, you know. It's been more geared towards females, and stuff. But there's never really been any, you know, male specific information. So you can't really judge the... if the only information that's demanded is for women ..."

An analogy can be drawn with the issue of anabolic steroid use among high school adolescent athletes. In a sample of Grade 12 grade boys, none were identified as users of anabolic steroids. However, the majority of the sample believed that others in their class were users. As well, the risk of steroid use in this group was high as indicated by body image dissatisfaction and lack of knowledge of the adverse effects of steroids (Wang, Yesalis, Fitzhugh, Buckley, & Smiciklas-Wright, 1994). Therefore, the actual numbers of people affected is not always documented accurately with the known information.

It may be difficult for men themselves to know what they need for resources. For example, there may difficulty not only in knowing about resources for males with eating disorders but also in identifying what they would find helpful.

♂: "..... you can't expect.. um.. a group with no resources to be able to develop their own resources, you know. They don't know what they need. Why should they be responsible for making sure that people know what they need, when they don't even know what they need themselves?"

4.5.3 Nutrition Information

Several men saw nutrition as crucial for developing healthy eating habits when people with eating disorders are ready to start eating well again.

♂: “Well, that’s really just a form of education. It is empowering yourself so that once you do decide to make the step into eating healthy and living a more healthy balanced lifestyle, then at least you have the background to be able to pursue that kind of endeavor, you know..... But it’s not useful in making... in the direct relationship with making you stop it.”

♂: “Something a little more nutritious. Get the higher nutritional values out of those few things that you do eat other than, you know, just sitting there and trying to figure out, “Well, why don’t you eat?” It’s like, well ok, so you’re not eating. That’s one point. Here’s what you should be... what you can be doing when you do feel like it.”

Dealing with the “whys” of eating behaviors is a different issue than having access to and using nutrition information.

4.6 Summary

There are a number of issues related to resources need. Resource availability in Canada is composed of some male specific resources, and some combination or non-gender specific resources. The internet and non-profit organizations provide resources as well. The format and design of information resources was noted as affecting how males receive the information and their notice of it. The focus of resources needs to be on specific target groups, such as high risk groups and influencing environments (family, schools, social groups). Types of information include general awareness and educating the public about males with eating disorders. Promoting males to come forward with eating problems was noted as a necessary focus of resources. In terms of access and location of resources, communicating the availability of existing resources is necessary. Resources that are anonymous and private and located in non-threatening environments were noted. The gender specificity of information resources was of relative importance - some participants noted

male specific, non-gender specific, and female specific resources as useful to males with AN or BN. The gender-mix of support groups may or may not be a problem for males with eating disorders; discouragement was an issue. There were mixed opinions on the usefulness of nutrition information - some participants saw it as absolutely necessary, and others as useless without addressing other issues. The internet was discussed as providing anonymous resources, general awareness, and support for males with eating disorders. Personal and community support was discussed as a resource necessary for disclosure and having support networks to address the eating disorder. Suggestions for resource development came from both the males and the health professionals, and noted both written and treatment resources.

There were a number of barriers related to resource access and use. The failure of family and friends to recognize the signs of an eating disorder were noted as contributing to a delay in addressing it. Participants noted that health professionals may not recognize an eating disorder in male clients because most of their other clients are women. As well, males themselves indicated that they may not know that they are experiencing an eating disorder. Because eating disorders are often seen as a “female disease,” men felt hesitant to express their eating problems and seek out resources to address them. The societal view of “the strong man” who is unaffected by emotion or food problems was noted as contributing to hesitation to seek help. A sense of isolation and feeling like the only man with an eating disorder were mentioned as contributing to feeling that there is a lack of resources.

Results from the feedback process were generally consistent with the themes that arose during the initial interviews. There was no feedback received from the summary notes sent to health professionals. There was also no feedback received from the male eating disorder participants who received the feedback report but declined a second interview. The three men who did participate in a second interview discussed many of the same issues that

were brought out in the first interviews. Additional information included: 1) that written information should be used as a first step to further resources; 2) that men with eating disorders may be using female specific resources now, hiding a greater need for male specific information; and 3) that nutrition information would be useful when individuals with eating disorders are ready to focus on healthy eating and nutrition.

Chapter 5 - Summary, Implications, and Recommendations

5.1 Summary by Research Question

1. What treatment resources and educational programs are available in Canada that are geared specifically to males with eating disorders?

A thorough resource search revealed several male specific resources related to eating disorders and related issues. Appendix Q is a list of those resources found. Their location is sporadic throughout Canada, and there was no central location for male specific information. There are few books related to males and eating disorders that are available in Canada. The Canadian Centre for Ethics in Sport has a project called “The Steroids and Body Image Project,” which targets steroid abuse and body image of male athletes. Pamphlets, posters, and fact sheets, used both as public awareness information and teaching tools, were found through eating disorders organizations. There was one activity kit found available from the Yukon Government on adolescent male body image. There was one male specific support group found located in Toronto. The internet provided a number of information sources. Appendix S is a list of websites that have male specific information related to eating disorders. They are a mixture of research, awareness, support groups, and eating disorders organizations.

Both the health professionals and the males knew of little or no male specific treatment and information resources in Canada. Many organizations contacted did not respond to requests for male specific resources of any type. Many organizations responded, but did not have any male specific resources available. The availability of male specific treatment resources needs to be researched on a local level, as there may be

private groups and programs. As well, eating disorders organizations in Canada often share information and may obtain it from other organizations in the U.S. The availability of male specific information from non-profit groups, then, also needs to be researched on a local basis.

2. What do health professionals who work with eating disordered adolescents and adults identify is needed for treatment resources and education for males with eating disorders?

The health professionals discussed the availability of and need for treatment and information resources. They identified the need for credible information from professional resources. They were unsure of the format that would be most appealing to males. Using a team approach to treatment and educating professionals on males and eating disorders were noted as important. Focusing on family, social groups, and schools were seen as crucial. Male specific resources were seen as important to promote males to seek help for an eating disorder - media, role models, and information were seen to help decrease the hesitation to admit to an eating disorder. When offering information to eating disorder clients, health professionals noted that it is important not to bombard them with too much detail and that patient need and desire determines what resources are offered. They identified a need for male specific treatment and education resources, but also proposed the use of non-gender specific resources to help males. They also questioned the cost-effectiveness of having a number of specific resources for a very small group. Changing the language of written resources from feminine to neutral was suggested. Relating to treatment resources, many professionals felt that males would do best in an all male support group, but question if there are sufficient numbers of men with eating disorders in any one location to do so. They identified the use of nutrition information as helpful for eating disorder clients to learn to put together a healthy diet; misinformation was seen as a danger. Internet information was thought to be very general

but was seen as a potential source of information for the males themselves.

Health professionals had several suggestions for developing resources for males with AN or BN. Adapting already existing resources to be less female oriented and more relevant to males was suggested. Promoting services and awareness through written information was noted; this could be done through professional organizations, and media. Male specific information, using media for awareness and education, anonymous resources, information available in schools, and educating professionals were thought to be needed. Communicating the existence of support groups that would involve males and having a crisis phone line were suggestions related to support and communication. Encouraging men to come forward with their eating problems was considered important.

The health professionals discussed a number of barriers related to resource access and use by males with eating disorders. They identified lack of recognition of eating disorder symptoms in males by family, friends, other health professionals, and the men themselves as a barrier - the reasons were thought to be because there are many more females with eating disorders, and professional experience with males is limited. The idea that eating disorders are a “female disease,” as seen by the public, the men themselves, and professionals, was also noted as a barrier. They felt that societal expectations of men’s roles and men feeling the need to be strong and not show emotion may cause men to hesitate to seek treatment and information for eating problems. Feelings of isolation of being the only man with an eating disorder were also noted to contribute to the secretiveness of men having an eating disorder.

3. What do males who have anorexia nervosa or bulimia nervosa identify as being useful, relevant, and accessible to them in terms of treatment resources and education?

Males felt that resources that are quick and easy to read, such as pamphlets, would be appealing and a good way to find out about further information. Media was

considered a resource by the men. Written information that was designed very “femininely” was not considered appealing to the men, and in some cases was seen as insulting. The men felt that information resources should be targeted on specific issues related to eating disorders; family, social groups, schools, and high risk groups were seen as important. Specific information for resources might include awareness and recognition of eating disorders in males. In terms of treatment resources, the men felt that looking at the underlying causes of eating disorders was important. Being able to relate to other men with eating disorders was noted as helping to encourage men to come forward with eating disorders. The men expressed a desire to know what resources are available for them to deal with their eating disorders. Information that is accessible anonymously and that can be read in private was a crucial characteristic - having to admit to the eating disorder to get information was seen as a deterrent. Information resources was suggested to be most accessible when they are out in the open, in multiple locations, and in places where men congregate and would be likely to notice them (gyms, organizations, schools). The men were divided on their opinion of the gender specificity of resources - some felt that male specific resources would be best to use, some felt that female resources were ok, and some felt that non-gender specific resources would be best to appeal to the most people. All felt that there needs to be more male specific information related to eating disorders for awareness and recognition. In terms of support groups, some men felt that mix-gender groups might contribute to feelings of isolation. It may be discouraging for the males when others in the group do not improve in health status. Nutrition information was also viewed with mixed feelings - some men saw it as crucial to addressing their eating disorder, but others felt that it was useless without addressing the underlying issues. The internet was discussed as both an information and a support resource; the men found articles, testimonials, on-line support groups, and research on the internet to

be helpful, and the anonymity of it was the greatest appeal. Personal and community support were seen as necessary to access other resources. The men were more likely to actively seek treatment and information if they were able to disclose an eating problem comfortable and if they felt support.

There were a number of suggestions from the men for developing treatment and information resources. Visual and written resources that acknowledged the wide variety of people who can be affected by eating disorders was seen as most important. Increasing awareness through media and visual items (posters, pamphlets) were thought to help decrease feelings of isolation that men might experience related to an eating disorder. Written resources that were suggested included pamphlets and awareness education; neutral language, focus on high risk groups, and anonymous availability were thought to be good characteristics of written information. The best locations for resources were health care facilities, fitness centres, schools, organizations, and libraries. Community and support resources that were suggested included a “buddy system,” an “eating disorders hotline” (phone), and support groups where men could go. Media, as a source of information, was discussed as a resource for the men themselves; some of the forms of media included television and printed media.

The men also discussed a number of barriers related to their access and use of treatment and information resources. These barriers included failure to recognize the eating disorder, the perception that eating disorders are a “female disease,” the need to maintain a “strong man” image, and a sense of isolation.

5.2 Implications for Health Professionals

The results of this research indicate several actions that health professionals might take when dealing with eating disorders. The implications mainly focus on health professionals that deal with eating disorders in their profession; health professionals who

do not deal directly with eating disorders could also benefit from this information.

1. Increase self-education on males with eating disorders. Although they are a relatively small group compared with the number of female clients that a professional might see, professionals must be able to recognize the signs of eating disorders in males and acknowledge them early on so that clients may get help.

2. Become aware of various sources of eating disorders information resources.

Develop a list of resources specific to males with eating disorders to offer male clients.

3. Encourage a team approach to treating eating disorders. Develop networks among various professionals for the purposes of information and experience sharing. In this way, when presented with a male eating disorders client, professionals will be able to connect with others who may have insight or resources.

4. Learn about eating disorder organizations outside the immediate area which may be a source of valuable information on males with eating disorders.

5. Become more aware of internet resources for professionals and eating disorder clients. Where there are no immediate services available, on-line support groups and information may provide a temporary solution to the need for support and education.

6. Use caution when presenting nutrition information to eating disorder clients. Education on healthy eating should be presented as part of the “team approach” and in the context of dealing with the underlying issues. As well, be aware of the dangers of misunderstanding nutrition information when accessed without professional input.

7. Encourage men to express their feelings and emotions related to food and other issues. This helps counteract the “strong man” image that may be preventing them from dealing with an eating disorder. Offer an outlet for expression; refer males to various social and support groups, and promote personal activities for dealing with emotions (e.g., keeping a journal). In this way, males who are not comfortable expressing their

emotions to others will begin to identify their feelings within themselves, which may eventually encourage them to approach others.

8. Become active in advocacy towards eating disorders organizations for specific information and treatment resources. Where professionals detect a service that is lacking for their clients, advocacy to appropriate organizations will help to increase support for the development of needed resources.

5.3 Implications for Males with Eating Disorders

The results of this research indicate several issues that males with AN or BN need to become aware of and apply to their lives. The implications may be specific to males experiencing an eating disorder; however, they may be applied to males in general who might encounter other males with AN or BN.

1. Understand that although most treatment resources are not male specific, there are some resources for males with eating disorders. Most treatment programs will accept males.

2. Actively seek information and become aware of organizations to contact for information and treatment resources related to eating disorders.

3. Be confident in your concerns about disordered eating behaviors. Know that you are not the only man with problems with food and eating. Bring your concerns to organizations and professionals who may help you access the resources you need.

4. Increase awareness of the signs of eating disorders. Learn to recognize when dieting and eating behaviors are becoming dangerous either for yourself or for others.

Talk to health professionals, teachers, and guidance counselors about where to get general information about eating disorders and healthy body weight. Go to the library and the health clinic for books and information. This will help you to understand the significance of dieting and eating behaviors.

5. Men need to be aware of their own body images and the messages that they may be sending to others vulnerable to eating disorders. Often, even the most seemingly harmless comments can have a powerful negative effect on a person's self-esteem and body image.
6. Learn to evaluate the credibility of nutrition and internet information. When considering changes in dietary habits, understand that not all information is reliable or promotes healthy behaviors. Talk to health professionals or visit your local health unit to find out about how to tell when the information you have is reliable and true.

5.4 Recommendations

5.4.1 Resources to be Developed

Several treatment and information resources might be developed for males with eating disorders. The recommendations for resource development focus on the broad categories of resources that need to be considered during eating disorders treatment and education.

5.4.1.1 General Directions

1. Design gender-neutral resources. Written resources that are designed more neutrally and treatment resources that appeal to both men and women can be cost effective (compared to designing male specific resources). Both genders may be encouraged to seek help with gender neutral resources.
2. Increase education for the public (thereby reaching individuals with eating disorders) and through treatment on the similarities between men and women with eating disorders. This will help males and females to understand each others experiences related to an eating disorder, help them to be aware that both males and females do get AN and BN, and help them to be more comfortable in sharing treatment and information resources (e.g., support groups).

5.4.1.2 Specific Resource Types

1. Develop more written information resources specific to males and eating disorders - pamphlets, articles, etc... This contributes to awareness of the eating disorders in males and offers the males options to seek help.
2. Increase awareness of eating disorders in men through media avenues, such as magazines, television, newspapers, radio, and other visual resources. Media has a far reach, and can be used for both general awareness and promotion of treatment resources.
3. Create targeted interventions for high risk groups related to eating disorders. For example, there have been a number of intervention programs designed specifically for female adolescents related to body image, peer pressures, and dieting. Prevention can target high risk groups of males who might be at risk of developing an eating disorder - encouraging acceptance of a variety of body shapes (not just the “ideal” V-shape), educating on physical development and changes during adolescents specific to boys, offering coping mechanisms to handle peer pressure, encouraging boys to talk about the things that make them feel bad about themselves (e.g., discussion groups, lesson plans), and encouraging boys to advocate to media about their dissatisfaction with the “ideal” pressures in the media.
4. Improve professional education on eating disorders - groups affected, issues faced. This will help professionals be more aware of eating disorders in general, especially in males, and may contribute to more accurate and prompt diagnosis of an eating disorder. Professional education may be through conferences, workshops, in-services, interdisciplinary seminars, and networks (both personal and on the internet); individuals who are knowledgeable on males with eating disorders may be invited to attend these sessions to offer knowledge and resources.
5. Integrate eating disorders education into school curriculum - for example, lesson

plans for health class and guest lecturers. More focus on eating disorders in school may target issues that adolescents face related to peer pressure and body image.

6. Compile resource and service availability lists. The focus on practical information - where to go, what to do - will encourage males to come forward with eating disorders and actively seek help.

7. Train more individuals, male and female, to facilitate eating disorder support groups. Facilitators may or may not have had an eating disorder in the past, but their facilitation skills will increase opportunity to have more support groups; these support groups can then be encouraged to accept and address the issues of males with AN and BN.

8. Strengthen forms of follow-up support for individuals who have gone through treatment for eating disorders. As many individuals continue to experience body distress and negative body image even after formal treatment, it is important to integrate education into various forms of support. Psychoeducational groups, for example, may follow-up with specific education on coping mechanisms and reinforcing positive body image attitudes. As well, social groups that involve the target group which an individual is a member of (i.e., adolescents) may also conduct education on positive body image and how to fight bad feelings about the self and the expectations of having “ideal” looks. It is important, then, to alert individuals going through treatment what follow-up support is available, and encourage them to take part.

9. Where it seems that male athletes are one high risk group for the development of eating disorders, there is indication for the development of education for coaches and teachers. Information about healthy body weights, healthy ways to gain and lose weight for competition, and communication with adolescent athletes may help prevent misinformation from being communicated and promote a wider acceptance of a variety of

body weights in competition. Education may be through written information, in-services, conferences, and other professional education avenues.

Other suggestions for specific written resources, as identified by the health professionals and the men, can be found in the section of Chapter 4, “Suggestions for Developing Treatment and Information Resources.”

With these recommendations, health professionals and educators need to consider the cost effectiveness of developing specific resources for a relatively small group. In keeping with the principles of public health and health promotion, the goals of resource development need to focus on areas that will benefit the greater amount of people. The overall recommendation, then, is to increase attention to the issue of males with eating disorders, to acknowledge that males do get AN and BN, and to incorporate those issues into eating disorders education and awareness. Resource development specific to males should take place where funding permits.

5.4.2 Overcoming Barriers to Make Resources More Accessible

The results indicated several barriers that may inhibit males with eating disorders from accessing available treatment and information resources. These included lack of recognition of the eating disorder, the “female disease” perception, the “strong man” image, and a sense of isolation. Several actions related to education and resource development are recommended to help males overcome these barriers. These recommendations focus mainly on health professionals and educators working in health promotion and resource development. The goal of these recommendations is to promote recognition of the signs of an eating disorder in males, to encourage males to express problems with disordered eating, to decrease feelings of isolation and embarrassment, and to alert others to respect the struggles of men with AN and BN.

1. Communicate the availability of male specific resources through public

information sources (e.g., libraries, newspapers, other media, health units).

2. Encourage support groups to promote the acceptance of males and females in a support group.
3. Educate the public and men themselves on the fact that males can get eating disorders, and on the issues that contribute to the development of AN and BN (e.g., low self-esteem, “ideal” body images, lack of coping skills). Media, visual resources (e.g., posters), written information (pamphlets, fact sheets, brochures), and public forums during Eating Disorders Awareness Week provide an excellent opportunity to do this.
4. Help families to notice the signs of an eating disorder in their sons and not just their daughters. The warning signs are the same for boys and girls - obsession with weight and shape, using their body to evaluate self-worth, depression, social withdrawal, severe food restriction, constant dieting, frequent weighing, hoarding of food, use of laxatives or diuretics for weight loss, and oversensitivity to criticism are some examples. Written information, media, and public information sessions may provide opportunity to educate families that adolescent boys and men can experience these issues as well.
5. Provide professional education on eating disorders in males and the resources available for them. Conferences, interdisciplinary committees, in-services, and research updates can provide information on the issues that males face related to eating disorders; as well, these avenues can communicate the availability of treatment and information resources and generate ideas for resources that would benefit males with eating disorders.
6. Encourage males to express emotions and offer support for them to do so. This applies to professionals, family, and friends - not only is it important for males to express emotions in a therapeutic setting but also in everyday life. Emotions may range from depression to low self-esteem to sadness. Encouraging family discussions, asking an individual how they are doing, noticing signs that something is wrong, and being open

yourself about your own feelings will make it “ok” for males to express their problems and feelings.

7. Encourage professional networking so experiences with male eating disorder clients. Again, conferences, committees, networks (i.e., with regular newsletters sent to a professionals who could become members), and invitations to research events may encourage networking.

8. Remove the “female disease” stigma through development of gender-neutral and male specific treatment and information resources. This is also accomplished through public and professional education, and the acknowledgment in any eating disorders work that is done that AN and BN do affect adolescent and adult males.

9. Emphasize that approximately 10% of eating disorders occur in males, instead of only saying the opposite, that 90-95% of eating disorders occur in women.

10. Recognize the issues that adolescent boys feel related to their body image and weight - focus education on teachers, coaches, family, and peer influences. Written and professional education and curriculum development (e.g., lesson plans, guest lecturers, project assignments) could encourage discussion of some of the struggles that adolescent boys face. Targeted interventions, such as a nutrition education program for athletes and education for coaches on eating disorders, can also focus on groups that are at high risk for development of an eating disorder.

5.5 Limitations

The following are some general limitations to the current study:

- Eating disorders is a very sensitive topic, which may have impacted on the information volunteered by male participants and limited discussion on some topic areas.
- Specific criteria for participation and being a relatively small proportion of the population lead to a small sample size. Participants may not be representative of

all males with eating disorders.

- Because the interviewer was female and the participants male, there may be the potential for information bias where the men were select about the information that they offered.
- Identifying male participants with AN or BN was difficult as many of them may not be known. Participants included only those identified by health professionals with eating disorders and did not include other men who might be suffering with eating disorders.
- There is the potential that researcher bias has influenced the results. The researcher felt that the issue of males with AN and BN was important and that treatment and information resources for this group was lacking. This may have affected the way the data was understood and interpreted.

5.6 Areas for Further Research

The results of this research point to several areas that need further attention as they apply to the resource needs of males with eating disorders. Further knowledge about the issues that affect males with AN and BN is needed. What is the effect of women's perceptions of an "ideal" male body image on self-esteem of males? How do males deal with other psychological and psychiatric issues in terms of expression and access of resources? How does body image affect eating behaviors in men - i.e., what are the major influences on male body image? What influences help men feel more positive about their body image? As well, more research is needed on the contributing issues which are similar and different between males and females with eating disorders; this may point to areas for targeted intervention.

The area of resources for males with eating disorders is in need of more research. It would be important to understand what types of resources men consult for help and

information related to other health issues. For example, with addictions, what are the treatment and information resources used? What format is most appealing to them? Is there a difference in information resources that appeal to homosexual or heterosexual men (and thereby do we need different resources for each group)? What effect does gender have on the dynamics of support groups? Specific types of resources may be the focus of future research. What are the media formats that men are in contact with most often? What are the television and printed media messages for the “ideal” male body? Critical analysis of information resources is needed. Female oriented resources could be tested with males for understanding and identification with the information and issues. As well, an “adaptability test” could be conducted; here, female resources could be adapted for males with eating disorders and evaluated for understanding and identification with the information as well. As well, an evaluation of existing support programs for process, effectiveness, and adaptability to males may provide direction for the integration of males into support groups. A critical analysis of internet resources for information and support would shed light on credibility. An analysis of the resources that are available for the professionals and for the men would be useful. Are the resources adequate to address the specific needs of men with eating disorders? Are they understandable and practical for use by male eating disorder clients? It would be important to identify organizations for men where they might access information resources related to a variety of issues to pinpoint accessible locations for information.

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Appendix A

Diagnostic Criteria of Anorexia Nervosa and Bulimia Nervosa

Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though under-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 denial of the seriousness of the current low body weight.

D. In post-menarchal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen administration).

Specify type:

Restricting type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Source: The American Psychiatric Association, 1994, p.544-545.

Diagnostic Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

(1) eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people eat during a similar period of time and under similar circumstances.

(2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behavior both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specify type:

Purging Type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Non-Purging Type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Source: The American Psychiatric Association, 1994, p.549-550.

Appendix B

Qualitative and Quantitative Paradigm Assumptions

| Assumption | Question | Quantitative | Qualitative |
|-----------------|--|--|---|
| Ontological | What is the nature of reality? | * Reality is objective and singular, apart from the researcher. | * Reality is subjective and multiple, as seen by participants in a study. |
| Epistemological | What is the relationship of the researcher to that researched? | * Researcher is independent from that being researched. | * Researcher interacts with that being researched. |
| Axiological | What is the role of values? | * Value-free and unbiased. | * Value-laden and biased. |
| Rhetorical | What is the language of the research? | * Formal. * Based on set definitions. * Impersonal voice. * Use of accepted quantitative words. | * Informal. * Evolving decisions. * Personal voice. * Accepted qualitative words. |
| Methodological | What is the process of the research? | * Deductive process. * Cause and effect. * Static design - categories isolated before study. * Context-free. * Generalizations leading to prediction, explanation, and understanding. * Accurate and reliable through validity and reliability. | * Inductive process. * Mutual simultaneous shaping of factors. * Emerging design - categories identified during research process. * Context-bound. * Patterns, theories developed for understanding. * Accurate and reliable through verification. |

Source: Creswell, J.W. (1994).

Appendix C

Resource Description Form



Adolescent and Adult Males with Eating Disorders and Related Concerns

Resource Description Form

TITLE OF RESOURCE:

ORIGINATOR: (author, organization, bibliographic information)

FORMAT AND LENGTH: (book, pamphlet, video, teaching manual, support/therapy group, etc...)

TARGET GROUP: (gender, age, related to a particular activity, etc...)

GOAL/PURPOSE:

DESCRIPTION OF CONTENTS:

METHOD OF DISTRIBUTION: (mail-out, in person, order form, monetary cost, etc...)

MEANS OF PROMOTION: (how would people know where to find this)

Dianne Oickle, College of Pharmacy and Nutrition, University of Saskatchewan, 1997. For use as part of her Master's thesis entitled "A Needs Assessment of Educational and Support Resources for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa". Not for use for any other purpose.

Appendix D

List of Organizations Contacted for Resources

Sports Nutrition Advisory Committee
c/o Sport Medicine & Science Council of Canada
1600 James Naismith Dr., Suite 502
Gloucester, ON K1B 5N4

Canadian Centre for Ethics in Sport
1600 James Naismith Dr., Suite 702
Gloucester, ON K1B 5N4

Bulimia Nervosa Association
3640 Wells Ave.
Windsor, ON N9C 1T9

National Institute of Nutrition
265 Carling Ave., Suite 302
Ottawa, ON K1S 2E1

Saskatchewan Dietetic Association
Box 3894
Regina, SK
S4S 6X6

Saskatchewan Public Health
Association
Box 845
Regina, SK S4P 3B1

Hon. Alan Rock
Minister of Health
Health Canada
P.L. 0916A
Booke Claxton Building
Tunney's Pasture
Ottawa, ON K1A 0K9

Health Protection Branch
Building #7
P.L. 0701A1
Tunney's Pasture
Ottawa, ON K1A 0L2

Food Directorate
Bureau of Nutritional Sciences
Rm. 103 Health Protection Building
P.L. 0701A5
Tunney's Pasture
Ottawa, ON K1A 0L2

Food Directorate
Nutrition Research Division
Rm. 103 Health Protection
Building
P.L. 0701A5
Tunney's Pasture
Ottawa, ON K1A 0L2

Food Directorate
Nutrition Evaluation Division
Rm. 103 Health Protection Building
P.L. 0701A5
Tunney's Pasture
Ottawa, ON K1A 0L2

Health Promotion and Programs
Branch
Rm. 1614 A
Jeanne Mance Building
Tunney's Pasture
Ottawa, ON K1A 1B4

Health Promotion and Programs Branch
Planning and Coordination Division
Rm. 1614 A
Jeanne Mance Building
Tunney's Pasture
Ottawa, ON K1A 1B4

Health Promotion and Programs
Branch
Strategies and Systems for Health
15th Floor
Jeanne Mance Building
Tunney's Pasture
Ottawa, ON K1A 1B4

Health Promotion and Programs Branch
Child and Youth Division
Rm. 2137 Finance Building
P.L. 0202C1
Tunney's Pasture
Ottawa, ON K1A 1B4

Health Promotion and Programs Branch
Population Health Directorate
17th Floor
Jeanne Mance Building
Tunney's Pasture
Ottawa, ON K1A 1B4

British Columbia Department of Health
Rm. 310, Parliament Buildings
Victoria, B.C. V8V 1X4

British Columbia Department of Health
5th Floor, 1515 Blanchard St.
Victoria, BC V8V 3C8

Alberta Department of Health
Rm. 228 Legislature Building
Edmonton, AB T5K 2B6

Alberta Department of Health
18th Floor
10025 Jasper Avenue
P.O. Box 2222
Edmonton, AB T5J 2P4

Saskatchewan Health
Rm. 334, Legislative Building
Regina, SK S4S 0B3

Saskatchewan Health
T.C. Douglas Building
3rd Floor, East Wing
2475 Albert ST.
Regina, SK S4S 6X6

Manitoba Department of Health
Rm. 302, Legislative Building
450 Broadway
Winnipeg, Man. R3C 0V8

Manitoba Department of Health
Rm. 308 Legislative Building
450 Broadway
Winnipeg, Man. R3C 0V8

Ontario Department of Health
Queen's Park
Hepburn Block, 10th Floor
80 Grosvenor St.
Toronto, ON M7A 2C4

Quebec Department of Health
Edifice Catherine-De Longpre
1075, Chemin Sainte-Foy, 15th Floor
Quebec (Quebec) G1S 2M1

New Brunswick Department of Health
7th Floor, Carleton Place
520 King St., P.O. Box 5100
Fredericton, NB E3B 5G8

Nova Scotia Department of Health
4th Floor, Joseph Howe Building
1690 Hollis St., P.O. Box 488
Halifax, NS B3J 2R8

Prince Edward Island Department of Health
2nd Floor, Jones Building
11 Kent St., P.O. Box 2000
Charlottetown, PEI C1A 7N8

Northwest Territories Department of Health
6th Floor, Laing Building
P.O. Box 1320
Yellowknife, NWT X1A 2L9

Yukon Territory Department of Health
2071 - 2nd Ave.
P.O. Box 2703
Yukon Government Administration Building
Main Floor
Whitehorse, Yukon Y1A 2C6

Newfoundland and Labrador Department of Health
Confederation Building, West Block
Prince Philip Dr.
P.O. Box 8700
St. John's, NF A1B 4J6

National Eating Disorders Information Centre
College Wing 1
211 Elizabeth ST.
Toronto, ON M5G 2C4
(416) 340-4156

Dietitians of Canada
www.dietitians.ca

Canadian Public Health Association
<http://www.cpha.ca>

Appendix E

Cover Letter for Health Professional Recruitment

(on university letterhead)

(date)

(address of health professional)

Dear xxxxxxx,

My name is Dianne Oickle and I am a graduate student at the University of Saskatchewan. I am currently conducting research for my Master's degree on males with eating disorders. The title of my thesis is "A Needs Assessment of Educational and Support Resources for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa".

I am writing you this letter to ask for your help in contributing to my research. The purpose of my study is to assess the availability of resources that address the specific needs of males who have an eating disorder. Specifically, I am looking at what kind of resources are available, where they can be found, how they are being used, and how the male clients feel they are in terms of usability and appropriateness. The structure of my research will involve a thorough search for resources across Canada through contacting national, provincial, and local eating disorders organizations, government departments and professionals, as well as a series of group interviews with health professionals associated with eating disorders interventions and individual interviews with adolescent and adult males with anorexia and/or bulimia.

I would like to invite you to participate in a group discussion surrounding the issue of male eating disorders. Other health professionals from a variety of disciplines who have had experience in dealing with eating disorders (male or female) will also be involved. We will be covering such topics as experience in dealing with males with eating and body image concerns, use of resources in addressing this group, and resource related issues that need to be addressed with respect to eating disorders in males. Your current personal experience with male patients specifically is not absolutely necessary, as any experience in eating disorders intervention will provide valuable and helpful information on the topic of this study. The date and time of the interview will be determined as professionals are confirmed during a period that fits with your schedule. The discussion will be approximately 1 ½ hours in length, and will be an open sharing of experiences and resources.

The other aspect of your participation that I ask is in helping to recruit male eating disorders clients for participation in my study. Your agreement in this matter is not

obligatory and is not necessary to participate in the group discussion. If this is possible, I would be giving you an invitation and consent package to pass along to any male clients or contacts you may have who have had personal experience with eating disorders, at which time they may contact me personally should they desire to participate. However, I would be happy to accept your participation in the group discussion without client recruitment.

Confidentiality throughout this study is completely assured. What you say and offer to the group discussion will not be shared beyond the group in any way that may identify you. As well, all members of the group will be asked to keep the proceedings confidential, and the results will be reported in such a way that they contribute to eating disorders resource development.

I will be contacting you during the week of September 1-5, 1997 at which time I will ask for your participation and explore possible dates for the end of September. Perhaps in the time until then you may consider any adolescent and adult males with anorexia or bulimia that you know who may be interested in my study. I will discuss this with you in September as well. Please do not hesitate to call me at 966-6346 (office) or at 374-6375 (home) or send an e-mail (OICKLE@SKYFOX.USASK.CA). My research supervisor, Dr. Shawna Berenbaum, may also be contacted (966-5836). We would be happy to discuss this project in further detail with you at your convenience.

Thank you for your interest and consideration in participating. I look forward to meeting you.

Yours truly,

c.c. Dr. Shawna Berenbaum, Research Supervisor

Appendix F

Cover Letter for Health Professional Phone Interviews

(on university letterhead)

(date)

(address of health professional)

Dear xxxxxxxx,

I am writing this letter to request assistance with my graduate research in the area of eating disorders. I would like to take this opportunity to describe my research and the goal of my communication with you.

The title of my graduate research thesis is “A Needs Assessment of Educational and Support Resources for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa”. There is seemingly little focus on males with eating disorders in research and health care, and questions as to where we should go from here. My intention is to discover the discrepancy (if any) between currently available resources and what is really needed or wanted by this group to help them cope with their illness. I plan to extensively review the literature pertaining to the subject, as well as to review national and provincial health departments, eating disorders organizations, and internet sites to discover what educational resources and programs are currently available to this group. As well, I will be interviewing health professionals and male patients with an eating disorder to get a personal perspective. My goals are to look at the prominence of the issue of males with eating disorders, availability of support services and education efforts, and use of resources in health care and by health professionals.

I am writing to you to ask for your help in my data collection. I have extended my research to include telephone interviews with health professionals across Canada who are involved with eating disorders education and research. I would like to hear of your professional experience with males with anorexia and bulimia, as well as any thoughts and insight on this issue. I would like to discuss the types of resources you have used with your male clients, what issues they cover, and how they are presented and received. I understand that you have specific professional experience with male clients and would be very interested in learning of some of the issues they face, as well as resources they have used and their experiences with them.

I would also like to ask for your help in identifying any national and/or provincial resources aimed at males with various health and body image concerns. Specifically, I am looking for any resources pertaining to body image (influences, “ideals”), eating concerns/problems, societal and cultural pressures, psychological issues, and methods of

weight control. For the purpose of my research, a “resource” could include any of the following: support groups, written information (pamphlets, books, etc...), media efforts, organizations specifically for eating disorders, professionals working in the area of eating disorders, health promotion programs, teaching and education tools. Anything that you can provide that relates in any way to the concerns of males with eating disorders and related issues would be extremely helpful and relevant.

Part of my research also involves speaking to individual males who have had or do have anorexia and/or bulimia. I am hoping to connect with them through the health professionals who I contact. I would also ask you to keep this in mind should you come across or have current clients/associates with an eating disorder. I would love to speak with them.

I will follow up this letter with a phone call sometime during the week of October 20-24, at which time I will ask to set up a designated time when we might have a telephone interview. I would be very happy to speak with you concerning my research at your convenience, and I would invite you to contact me at any time for any further information required. My **home** phone number is **374-6375**, and my **office** number is **966-6346**. As well, feel free to contact me via **e-mail (OICKLE@skyfox.usask.ca)** or **fax (306) 966-6377**. Please reply with any information you can provide, including if you do not have any specific professional experience with males and eating disorders. Any further personal, professional, or organizational contacts you can provide would also be extremely helpful.

Thank you for your time and consideration.

Yours truly,

c.c. Dr. Shawna Berenbaum, Research Supervisor

Appendix G

Interview Guide for Health Professionals (Group and Individual Interviews)

1. Describe some general thoughts on the issue of males with eating disorders. Do you think that it is a prominent issue in discussing eating disorders? What are some of the main issues that need to be addressed?
2. Describe what your professional experience has been with adolescent and adult males with anorexia nervosa and bulimia nervosa. What have been some of the issues that have come up? What have been the core issues surrounding their illness?
 - If you have had no professional experience with male eating disorder clients, do you have any thoughts about issues surrounding this group?
3. What is your knowledge of resources specifically for males with eating disorders? Where do they come from? What type/format are they?
4. What has been your experience using resources specifically for males with an eating disorder? Are they difficult to access? How do you know where to find them? What issues do they address?
5. Do you feel that there are resources or programs that need to be developed and/or offered to eating disorder clients, especially males?
6. What educational and support resources would promote males to cope with an eating disorder?
7. Who should be developing additional eating disorder resources for men? (and women?) Who/what groups should eating disorder resources be focused on in general? Issues?
8. Discuss your primary source of information resources concerning anorexia and bulimia (male or female) i.e., written, support, etc... How do you know where to go for resources? Which format do you find most useful?
9. Describe the types of information resources you most commonly use during the first meeting with an eating disorders client for their use. How do you present them? How are they received?
10. How do you promote your services as an eating disorder health professional? How would males with eating disorders know to contact you for service? Would they know how to contact you? How would they know if it is you they should contact?

11. If you are unable to provide appropriate resources (written and other information resources and treatment) to a male eating disorder client yourself, are there alternatives to refer them to? What are some of those alternatives?

Appendix H

Consent Form for Health Professional Group Interviews

Consent Form

A Needs Assessment of Educational and Support Resources for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa

The principal investigator of this research study is Dianne Oickle and it is in partial fulfillment of the Master of Science degree in Nutrition at the University of Saskatchewan. The purposes of the research include identifying resources currently available to males with eating disorders, and defining what additional resources and programs are needed for support, education, prevention, and recovery. The potential benefits of this study to health professionals associated with eating disorders are the provision of guidelines for the development and implementation of eating disorders resources, as well as an increased understanding of the specific issues. (However, there is no guarantee of or limit to what will result from this study).

This group interview is one of many that will be conducted with various health professionals associated with eating disorders. The semi-structured group format will allow for free and open sharing of experiences and thoughts; there are no right or wrong answers, and the researcher simply acts as a facilitator of the discussion. Cumulative results from the groups interviews will be fed back to you via a written summary report, should you wish to receive it. The interview will be audio recorded, if you so consent. My assistant will be taking notes for accuracy. The audio tapes will be kept in a locked desk drawer, and only the researcher will have access to them. The supervisor of the research and auditor of the study will have access to the written transcripts only, where no one will be identified. After the completion of the research and defense of the thesis, the audio tapes will be destroyed.

You are free to withdraw from the study and/or the interview at any time. There will be no negative thoughts about this, and it will not affect any possible working relationships you may have related to eating disorders research. If there is any additional information that arises relating to your decision to participate in this study, you will be notified immediately by the researcher.

Results of this research will be written in the form of a research thesis, which will then be available at the University of Saskatchewan library. As well, there will be attempt to publish results from this study in scientific journals and various community resources.

Please feel free to contact the researcher and/or research supervisor noted below at any time if you should have questions and/or comments.

Thank you for your participation in this study. ☺

Dianne Oickle
Graduate Student
University of Saskatchewan
966-6346 (office)
374-6375 (home)

Dr. Shawna Berenbaum
Associate Professor and Research Supervisor
University of Saskatchewan
966-5836 (office)

I have been informed of the structure of this study and the contents of consent. I understand the implications of this consent and will maintain a copy for my own records. I agree to participate in this research study.

Participant

Date

Researcher

Date

Witness

Date

Appendix I

Consent Form for Individual Health Professional Interviews

Consent Form

*A Needs Assessment of Educational and Support Resources
for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa*

The principal investigator of this research study is Dianne Oickle and it is in partial fulfillment of the Master of Science degree in Nutrition at the University of Saskatchewan. The purposes of the research include identifying resources currently available to males with eating disorders, and defining what additional resources and programs are needed for support, education, prevention, and recovery. The potential benefits of this study to health professionals associated with eating disorders are the provision of guidelines for the development and implementation of eating disorders resources, as well as an increased understanding of the specific issues. (However, there is no guarantee of or limit to what will result from this study).

This interview is one of many that will be conducted with various health professionals associated with eating disorders. The semi-structured format will allow for free and open sharing of experiences and thoughts; there are no right or wrong answers, and the researcher simply acts as a facilitator of the discussion. Results from the interview will be fed back to you via a written summary report, should you wish to receive it. The interview will be audio recorded, if you so consent. The audio tapes will be kept in a locked desk drawer, and only the researcher will have access to them. The supervisor of the research and auditor of the study will have access to the written transcripts only, where no one will be identified. After the completion of the research and defense of the thesis, the audio tapes will be destroyed.

You are free to withdraw from the study and/or the interview at any time. There will be no negative thoughts about this, and it will not affect any possible working relationships you may have related to eating disorders research. If there is any additional information that arises relating to your decision to participate in this study, you will be notified immediately by the researcher .

Results of this research will be written in the form of a research thesis, which will then be available at the University of Saskatchewan library. As well, there will be attempt to publish results from this study in scientific journals and various community resources.

Please feel free to contact the researcher and/or research supervisor noted below at any time if you should have questions and/or comments.

Thank you for your participation in this study. ☺

Dianne Oickle
Graduate Student
University of Saskatchewan
966-6346 (office)
374-6375 (home)

Dr. Shawna Berenbaum
Associate Professor and Research Supervisor
University of Saskatchewan
966-5836 (office)

I have been informed of the structure of this study and the contents of consent. I understand the implications of this consent and will maintain a copy for my own records. I agree to participate in this research study.

Participant

Date

Researcher

Date

Appendix J

Cover Letter for Male Eating Disorder Participant Recruitment

(on university letterhead)

(date)

Hi there!

My name is Dianne Oickle and I am a graduate student at the University of Saskatchewan. I am currently conducting research for my Master's degree in nutrition on males with eating disorders. The title of my thesis is "A Needs Assessment of Educational and Support Resources for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa."

I am writing you this letter to ask for your help in contributing to my research. The purpose of my study is to assess the availability of resources that address the specific needs of males who have an eating disorder. Specifically, I am looking at what kind of resources are available, where they can be found, how they are being used, and how practically useful they are to any male who is experiencing eating problems. The overall structure of my research will involve a thorough search for resources across Canada through contacting national, provincial, and local eating disorders organizations, government departments and professionals, as well as a series of group interviews with health professionals associated with eating disorders interventions and individual interviews with adolescent and adult males with anorexia and/or bulimia.

My personal motivation for conducting this study comes from my belief that no one is immune to the pressures of media and society to fit with an ideal body image. I am a firm believer that people are people and not just objects to be molded to look a certain way; we may be healthy at a wide range of sizes and shapes, and happiness is the most important thing. As an individual who is concerned about health and contentment, and as a health professional concerned about the well-being of the community, I know how important it is that the specific health issues particular to a health problem are adequately addressed in order to effectively cope and heal.

I would like to invite you to share your experiences with eating disorders resources and discuss how you feel the particular issues of male eating disorders are addressed. I have asked a health professional to pass on this letter to you as someone who will be able to provide invaluable information and input. The conversation will be one-on-one in a neutral, private location. I will not be asking questions about your past experiences that may have contributed to your eating problems, nor will I be asking personal questions about specific restricting or purging behaviors. The issues I would

like to discuss will be relating to your experience with resources such as support services, self-help tools, and professional consultation.

The date and time of the discussion will be determined at your convenience and during a period that does not interfere with your schedule. Complete confidentiality is assured. No one else will be present during the discussion, and no one other than myself will know your identity and that you are participating in my research. As well, our discussion will not be revealed in any way to (*name of health professional*) who has referred you to me, nor to my research supervisor or anyone associated with my project at the university. All thoughts and ideas will be non-identifying and used for the purposes of developing practical information for the design and implementation of eating disorders resources specifically for males with eating disorders.

After the initial discussion, I will be approaching you for further contribution to my research. I will be asking for the opportunity to have a second discussion with you or for your participation in a group interview with other male eating disorder individuals. The purpose of the second discussion will be to feedback the cumulative results from the series of individual interviews as well as the information revealed through group interviews with health professionals to provide you with an opportunity to offer input regarding the ideas and themes that emerge from all of the discussions. Participation in either of these second discussions is not obligatory and will not reflect on your contribution in the initial discussion. If you do not wish to participate in a second discussion of any form, that is absolutely fine and there will be no negative thoughts about this. Feedback will be made instead through a written summary report sent to you for opportunity for clarification and comment. You do not have to make a decision regarding this second discussion now; the request will come after the initial conversation at which time you can decide based on your experience with the study.

Please read the consent form that is included with this letter and return to me at the above noted address. I will then contact you personally to arrange for us to meet prior to your involvement in my study. Please do not hesitate to call me at 966-6346 (office) or at 374-6375 (home) or send an e-mail (OICKLE@SKYFOX.USASK.CA). I would be happy to talk with you in further detail about this project at your convenience. You need not give a name or phone number if you simply wish to find out more about me and my research. I would be happy to simply talk with you.

Thank you for your interest and consideration of participating. I look forward to meeting you.

Sincerely,

cc. Dr. Shawna Berenbaum, Research Supervisor

Appendix K

Interview Guide for Male Eating Disorder Participants (Initial Interview)

1. Describe the structure of the treatment you have received. (counseling, hospitalization, group therapy, geographical, etc...) Which aspects were helpful and which were not?
2. Which information resources have been suggested for you to use/refer to about your eating disorder during the course of your treatment. Treatment resources? By health professionals? By friends, family, others?
3. What types of resources have you actually consulted about your eating disorder? (i.e., books, videos, organizations, support groups). Treatment? Information? Which were useful? Why or why not?
4. What kinds of resources did you prefer using (i.e., videos, books, etc...)? Why? Were they easy to access? Were they easy to use?
5. Describe your main source of educational resources and/or information on the issue. Where do you go when you need or want information? Other alternatives?
6. Is there any type of help for your eating disorder that has been difficult to find and/or use? What additional resources would have been/would be helpful in dealing with your eating disorder? Treatment? Knowledge/information? Who should be developing? What would be most credible to you?
7. Describe your thoughts on barriers for seeking help for an eating disorder. Do you think there are barriers specific to men who have eating disorders?? What are some of the barriers you have experienced? How can they be addressed?
8. Where should resources for males with an eating disorder be found? What would make them most accessible?
9. What are your thoughts on the attention given to the issue of males with eating disorders? By eating disorders organizations and health care?
10. Describe some of your general thoughts on the issues that concern men who have an eating disorder? Influences on body image and weight?

Appendix L

Consent Form for Male Eating Disorder Initial Interviews

Consent Form for the Primary Interview

A Needs Assessment of Educational and Support Resources for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa

The principal investigator of this research study is Dianne Oickle and it is in partial fulfillment of the Master of Science degree in Nutrition at the University of Saskatchewan. The purpose of the research include identifying resources currently available to males with eating disorders, and defining what additional resources and programs are needed for support, education, prevention, and recovery. The potential benefits of this study to health professionals associated with eating disorders are the provision of guidelines for the development and implementation of eating disorders resources for males, as well as an increased understanding of the specific issues of this group. (However, there is no guarantee of or limit to what will result from this study).

This one-on-one discussion is part of a series that will involve other individual males with eating disorders. The private nature of the conversation will allow for free and open sharing of experiences. Complete confidentiality is assured; your participation in this study will not be revealed to anyone associated with the university, nor to the health professional who has referred you. Cumulative results from the interviews will be fed back through a second individual or group interview (to be consented to later) or via a written summary should you prefer (without subsequent interviewing); this will provide opportunity for clarification and feedback. The conversation will be audio recorded, if you so consent. The audio tapes will be kept in a locked desk drawer, and only the researcher will have access to them. The supervisor of the research and auditor of the study will have access to the written transcripts only, where no one will be identified. After the completion of the research and defense of the thesis, the audio tapes will be destroyed.

You are free to withdraw from the study and/or the interview at any time. There will be no negative thoughts about this, and it will not affect any possible working or treatment relationships you may have related to eating disorders research. If there is any additional information that arises relating to your decision to participate in this study, you will be notified immediately by the researcher .

Results of this research will be written in the form of a research thesis, which will then be available at the University of Saskatchewan library. As well, there will be attempt to publish results from this study in scientific journals and various community resources.

Please feel free to contact the researcher and/or research supervisor noted below at any time if you should have questions and/or comments. Thank you for your participation in this study. ☺

Dianne Oickle
Graduate Student
University of Saskatchewan
966-6346 (office)
374-6375 (home)

Dr. Shawna Berenbaum
Associate Professor and Research Supervisor
University of Saskatchewan
966-5836 (office)

I have been informed of the structure of this study and the conditions of consent. I understand the implications of this consent and will maintain a copy for my own records. I agree to participate in this research study.

Participant

Date

Researcher

Date

Appendix M

Cover Letter to Describe Feedback Options for Male Eating Disorder Participants

(on university letterhead)

(date)

(address of male eating disorder participant)

Hi xxxxxxx!

I just wanted to drop you a quick note to say hi and fill you in on the progress of my project. I have been so lucky to have spoken with you and have your contribution to my research. It has helped me a great deal.

I know that when we talked last, I mentioned the opportunity to give you some feedback on some of the issues that have come out during my research, including other interviews with various people and some resources that I have come across. I wanted to write you this note to remind you of the options to give this feedback. The choice is absolutely yours, whatever you are comfortable with and is convenient for your schedule. One thing I can do is prepare a short written report summarizing some of the key issues and points relating to males with anorexia and the resource available. This would give you the opportunity to read the report and offer feedback and input on these results. Another option is for us to speak again privately regarding the issues that have come out of the research, where we can talk about what they mean to you and how they apply to your experiences. And the other option is to participate in a group discussion, where I would invite the other participants of the study to gather together and discuss the issues that have come up. This format would involve other men who have had eating disorders, sharing their experiences relating to the research.

I want you to know that I have no personal preference for the type of feedback that you choose. You are not obligated in any way to participate in any of the options. Should you choose to defer all three, that is completely fine and I fully understand. Should you choose to participate in one of the feedback options, which ever one makes you comfortable should be the one you indicate. There is not pressure in any way to choose one over the others.

I am hoping to conduct the feedback during the second or third week of January, 1998, if that fits with your schedules. I am leaving town on December 14, 1997 and will return on January 5, 1998 (Christmas holidays!). If you would like to contact me at any

time before or after these dates, please feel free. I will be calling you very soon after I get back in the new year to discuss this feedback with you further. Also, please feel free to contact my research supervisor, Dr. Shawna Berenbaum, at any time with questions or comments (966-5836, c/o College of Pharmacy and Nutrition).

Thank you so much for your participation and continued input to my research. I am greatly appreciative of all that you have offered. I look forward to speaking with you soon. Have a wonderful holiday season!

cc. Dr. Shawna Berenbaum (copy of letter without name and address of recipient)

Appendix N

Cover Letter for Male Eating Disorder Feedback Interviews

(on university letterhead)

(date)

(address of participant)

Hi xxxxxxxxxxxx!!

I wanted to drop you a quick line to touch base and connect with you about the next stage of my project. I hope that everything is going well and life in the new year has been happy!

It is important to me and to my research to have the chance to feed back to you some of the major results of my research thus far. I sent you a note before the holidays explaining the feedback options to you, and I wanted to follow up on that note. Briefly, the options are to participate in a second individual interview, to participate in a group interview, or to do neither choice. Regardless of your participation in a second interview, I will send you a written summary of the major results of my research within the next month.

I will be available to arrange a second interview of your choice until Monday, February 2. If you would like to participate in a second interview, please call me before that date (374-6375). If I do not hear from you by that date, then I will not schedule a second interview and would be happy to send along the written summary. Again, your participation will not affect this.

Thank you so much for your input to this research. I am so grateful for your participation.

Stay warm in the cold Saskatoon winter!!!! ☺

Appendix O

Interview Guide for Feedback Discussion with Male Eating Disorder Participants

Overall, neither the men with ED or the health professionals had very much knowledge of resources that are specific to men who have eating disorders.

1. Men with ED say that the most useful resources are those that reduce feelings of isolation and hearing the stories of others who have had serious eating disorders. Health professionals say the same, and identify the use of support groups as one of the main ways to do this.
2. Men with ED identify information on healthy eating as not very useful until other issues are dealt with. Health professionals say that they teach healthy eating habits as a way to address the eating disorder.
3. Both men with ED and health professionals are split on their opinions about resources, whether or not they should be male specific. However, health professionals say that there may not actually be any male specific resources because there is little request or demand for them, and we need to look at the greatest number of people that need the resources, which would be women.
4. Both men with ED and health professionals discuss that men express their feelings differently or are not as likely to express their feelings about eating problems. However, health professionals identify that men have personality pressures, whereas women have body pressures; and men deal with their issues through substance abuse and internalizing.
5. Men with ED identify that social support, role models, and identifying with others who have the same problems are most useful and might have been missing when the eating disorder started.
6. Men with ED say that the best place to have resources is somewhere they can be picked up anonymously. Doctor's offices, for example, would be a good place. They identify the major problem as not knowing where to get resources of any kind. Health professionals say similar things, adding that all the information in the world won't make a difference if the men don't want it or don't think that their eating is a problem/is important.
7. Both men with ED and health professionals say that shame, embarrassment, and the stereotypical "strong man" image prevents men from talking about their eating problems. And both say that lack of awareness of families and health professionals that it can happen in men also prevents them from addressing the issues. Men with ED say that

men need specific resources to help with this, and health professionals add that professionals need the resources to educate them.

8. Men with ED say that resources including research articles, books, internet, testimonials of other men, information on physical consequences of an ED, are helpful. Although they want resources to be anonymous, they add that having to be secretive about getting it adds to the sense of shame.

9. Health professionals say that support services and programs are generic and useful to both men and women. Men with ED say that formal services are often expensive, geographically unavailable, and hard to find; and it is hard to find out about services unless you are already seriously ill.

10. Men with ED identify that education about eating disorders needs to start with children and families, as well as in school where a lot of development takes place. Health professionals add that boys and girls have different developmental issues, and we have to be sensitive to this when addressing eating disorders in children and adolescents.

11. Men with ED say that information and resources that are designed “femininely” turn them off to reading them. Health professionals say that we can be too gender sensitive, and that most resources can be used by men as well.

Appendix P

Consent Form for Male Eating Disorder Feedback Interviews

Consent Form for Second Individual Interview

*A Needs Assessment of Educational and Support Resources
for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa*

The principal investigator of this research is Dianne Oickle and it is in partial fulfillment of the Master of Science degree in Nutrition at the University of Saskatchewan. The purpose of this research include identifying resources currently available to males with eating disorders, and defining what additional resources and programs are needed for support, education, prevention, and recovery. The potential benefits of this study to health professionals associated with eating disorders and males are the provision of guidelines for the development and implementation of eating disorders resources for males, as well as an increased understanding of the specific issues of this group. (However, there is not guarantee or limit to what will result from this study.)

As you have already participated in an initial individual discussion, the purpose of this conversation will be to feed back the cumulative results from the first round of individual interviews with males who have eating disorders as well as a series of group interviews with health professionals associated with eating disorders intervention. Any clarification, input, additions, and comments are welcome as we explore the implications of the information revealed. Complete confidentiality is assured ; your participation in this study will not be revealed to anyone associated with the university, nor to the health professional who has referred you. The conversation will be audio recorded, if you so consent. The audio tapes will be kept in a locked desk drawer, and only the researcher will have access to them. The supervisor of the research and auditor of the study will have access to the written transcripts only, where no one will be identified. After the completion of the research and defense of the thesis, the audio tapes will be destroyed.

You are free to withdraw from the study and/or interview at any time. There will be no negative thoughts about this, and it will not affect any possible working or treatment relationships you may have related to eating disorders research. If there is any additional information that arises relating to your decision to participate in this study, you will be notified immediately by the researcher.

Results of this research will be written in the form of a research thesis, which will then be available at the University of Saskatchewan library. As well, there will be attempt to publish results from this study in scientific journals and various community resources.

Please feel free to contact the researcher and/or research supervisor noted below at any time if you should have questions and/or comments. Thank you for your participation in this study. ☺

Dianne Oickle
Graduate Student
University of Saskatchewan
966-6346 (office)
374-6375 (home)

Dr. Shawna Berenbaum
Associate Professor and Research Supervisor
University of Saskatchewan
966-5836 (office)

I have been informed of the structure of this study and the conditions of consent. I understand the implications of this consent and will maintain a copy for my own records. I agree to participate in this research study.

Participant

Date

Researcher

Date

Appendix Q

Feedback Report for Male Eating Disorder Participants

A Needs Assessment of Educational and Support Resources
for Adolescent and Adult Males with Anorexia Nervosa and Bulimia Nervosa

Dianne Oickle, MSc candidate
College of Pharmacy and Nutrition
University of Saskatchewan
1998

(not for reproduction or use for any other purpose than feedback related to this research project)

The following is a summary of the major preliminary results from the research done thus far (January, 1998). This report summarizes the information given from the interviews with the seven men with anorexia and/or bulimia and interviews with 15 health professionals. The information is presented in no particular order and giving no preference to any individual. There are many different views and opinions on a variety of topics, and each is represented and respected here. The information presented here comes from transcripts and summary notes of the discussions and does not reflect the personal opinions of the researcher or academic team associated with the research. The purpose of this summary is not to note what the conclusions of the research are. Rather, it is simply to give an idea of what the major themes of the interviews were. This information will eventually be written into a thesis, from which recommendations for addressing eating disorders in males will be made.

A number of issues around *treatment* came up. Support groups were discussed to be uncomfortable, in some cases, when men and women both are in the group, and when both anorexia and bulimia are lumped together. As well, it may be frustrating when co-dependency happens and others do not seem to improve. Other issues included confusion when many professionals are involved. The problem is that underlying issues are often not addressed. Options used by men with eating disorders included private counseling, support groups, and no formal treatment - dealing with the issues themselves. It was noted that men need to come to the realization about the eating disorder on their own and that men do have access to the same care as women do for eating disorders but they may not know it. Other issues that came up include the need to deal with underlying issues first, and work on eating and exercise issues (then move to body issues).

The topic of *resources* generated much discussion. Men mentioned using written and visual information, media, professionals, and support groups as resources. Sources of information included family, friends, counselors, and self-discovery and searching. Professionals noted a number of resources as being useful to them for addressing eating disorders: non-gender specific types, manuals and teaching guides, Canada's Food Guide, support groups, and written information. Issues mentioned that need to be focused on include dealing with underlying issues, reducing isolation, seriousness and physical consequences, and awareness that it does happen in men. The gender focus of the information may or may not matter to the individual - if the information is for women or men specifically. It was noted that it is important to present information so that it gives hope, and male specific information may encourage men to come forward with eating problems. Problems with resources included little knowledge of what is available, confusing information, only having nutrition information (which does not address issues), not having someone to talk to, and whether we have adequate resources to address issues of men with eating disorders. It was discussed that resources need to address issues such as control, body image, and self esteem (which might be generic for both genders), be more sensitive to the feelings of guys, balance between good nutrition and taking focus off body (difficult to do), and consider what the men see as important - the information will only be useful if it is wanted. Some suggestions for resources included: phone line to call, education and awareness, adapting female resources, support groups for men with eating disorders, educational videos, more attention in schools and with children, educate parents and families about eating disorders in men, focus on communication and skills of expressing emotions, "buddy system" (such as in AA), showing the range of people who can be affected by eating disorders, and developing resources specifically for men's needs.

Support was also an issue. Some problems relating to support for men with eating disorders that were mentioned include that the issue gets lost in the shuffle of other family problems. As well, lack of recognition of the eating disorder by family and professionals may lead to disbelief of what is going on. Support was noted as being needed in the form of positive role models, hearing others' stories, eliminating fear of rejection, and promoting confidence to deal with issues.

The *issues* discussed relating to the eating disorder were varied. Factors that influence the eating disorder included dysfunctional families, fear of being "fat", perfectionism, substance abuse, overwhelming responsibilities, broken relationships, adolescence, painful situations in life, physical illness, sexual conflict, poor self-esteem, focus on appearance to compensate for failures, depression, competitive athletics, and media pressure. Some of the psychological issues related to how the eating disorder affects the individual included sense of being judged and using the eating as a way to control life. Food was mentioned as the "addiction of choice", taking place of other substances. "Forgetting to eat" and denial of a problem were mentioned as things that prevent men from even realizing what is happening to them in terms of eating disorders.

The issues that were noted as being important to address involved use of laxatives, family communication, healthy eating and exercise, effects of the illness on the whole family, and underlying issues other than food. As well, it was discussed that men have different issues to deal with than women, and adolescent boys have different developmental issues than girls. Personality pressures of men vs. body pressures of women were noted as accounting for some difference in eating disorders. As well, the misconception between “being in shape” and “losing weight” was noted as needing to be addressed.

There were a number of *barriers* that were mentioned relating to what men have to face with their eating disorder. It was discussed that the perception that eating disorders are a “woman’s disease”, denial, and a sense of shame may prevent some men from coming forward with eating problems. The expense and far away location of formal services was mentioned as a barrier for seeking formal treatment. Some other barriers that men mentioned included the overemphasis on homosexuality and eating disorders, high profile of eating disorders in women, professionals not recognizing symptoms, teenagers think they’re invincible, peer pressures to practice behaviors (steroids, purging), too much emphasis on athletes and not just regular guys, men themselves not thinking that eating disorders can happen to them, and societal views of men - that they need to be strong all the time, making it harder for men to express their feelings. There were suggestions for overcoming the barriers as well. These included encouraging men to come forward, being open that eating disorders can affect anybody, developing more promotional materials, educating the public to take away stigma, role models for men to relate to, and making it “ok” for men to be comfortable with their feelings.

In terms of *prevention* of eating disorders in men, there were a number of suggestions. Looking at reducing the risk to developing an eating disorder was noted as the primary point. Looking at family dynamics and how they contribute to self-esteem and body image was suggested as a good place to start. Other suggestions included encouraging coping skills in children, encouraging children that it is ok to feel emotions, and focusing on society’s views of “ideal” bodies. It was also mentioned that eating disorders are difficult to prevent because of the complicated issues involved, and the need to change societal views. As well, the difficulty in prevention was mentioned as difficult when men themselves may not even recognize that it is going to happen. In addition to this, taking away focus on body and labels placed on people was considered important in the prevention of eating disorders.

Appendix R

Audit Report

June 15, 1998

Once I received the audit package from the researcher I began by familiarizing myself with all the materials. The thesis was reviewed and then I self-selected two themes from section 4.2 and one theme from section 4.3. The following themes were selected for the audit:

| | |
|--------------------|---|
| <u>Section 4.2</u> | <u>Resource Needs and Issues</u> |
| Theme #1 | 4.2.3 Access and Location 4.2.3.1 Knowledge and Source of Resources 4.2.3.2 Communicating Availability 4.2.3.3 Presentation of Information to Clients 4.2.3.4 Anonymity and Privacy 4.2.3.5 Location |
| Theme #2 | 4.2.6 Nutrition Information 4.2.6.1 Benefits of Nutrition Information 4.2.6.2 Drawbacks of Nutrition Information |
| <u>Section 4.3</u> | <u>Barriers Related to Resource Access and Use</u> |
| Theme #1 | 4.3.1 Recognition of the Eating Disorder 4.3.1.1 Recognition by Friends and Family 4.3.1.2 Recognition by Health Professionals 4.3.1.3 Recognition by Men Themselves |

The three themes selected were traced from the findings presented in the thesis to the raw data collected from the interviews. Data from the male eating disorder participants and health professionals was reviewed. The research findings and summary were reviewed and found to be based in the raw interview data.


The audit package was found to be comprehensible; all materials were clearly labeled and coded by participant and interview type. The explanation coded for participant quotes were simple to follow and make the audit trail clear.

The themes selected for audit were found to be confirmable in the raw interview data. All

quotations from each of the themes were easily traced back to the original data. Inferences made by the researcher appear clear, logical, and unbiased. Accurate presentation of all references and interview components were made to the auditor. The overall study design was found to be highly confirmable.

The data was found to be dependable and appropriate for the researchers themes. Rational for findings within the thesis was always well-supported with examples and references from the interview data. The language of the respondents was concisely presented without bias, quotations were summarized occasionally to reduce wordiness but all crucial inferences remained.

In my opinion the researchers results were found to be trustworthy and strongly based in the raw data.


Sheila L. Brown Bsc. Nutr., P.Dt.
June 22, 1998

Appendix S

Confirmation of Ethical Approval



UNIVERSITY ADVISORY COMMITTEE ON ETHICS IN HUMAN EXPERIMENTATION

(Behavioral Sciences)

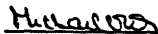
NAME AND EC #: Dr. Shawna Berenbaum (Dianne Oicle)
College of Nutrition and Pharmacy

97-102

DATE: June 30, 1997

The University Advisory Committee on Ethics in Human Experimentation (Behavioral Sciences) has reviewed your study, "A needs assessment of educational and support resources for adolescent and adult males with anorexia nervosa and bulimia nervosa" (97-102).

1. Your study has been APPROVED.
2. Any significant changes to your protocol should be reported to the Director of Research Services for Committee consideration in advance of its implementation.
3. The term of this approval is for 3 years.



Michael Owen, Secretary
for the University Advisory Committee
on Ethics in Human Experimentation, Behavioral Science

Please direct all correspondence to:

Michael Owen, Secretary
UACEHE, Behavioral Science
Office of Research Services
University of Saskatchewan
Room 210 Kirk Hall, 117 Science Place
Saskatoon, SK S7N 5C8

Appendix T

Profile of Health Professional Participants

In-person interviews:

- 2 groups (1 group of 3, 1 group of 4)
 - one 2-person interview
 - 6 individual interviews
 - all in Saskatoon
-
- 5 clinical dietitians
 - 2 private practice dietitians
 - 2 public health nutritionists/community dietitians
 - 2 psychiatrists
 - 2 social workers
 - 1 psychiatric nurse
-
- ⇒ 9 out of 15 had current or past male clients with anorexia or bulimia

Telephone interviews:

- 1 medical doctor (Toronto)
 - 2 psychiatrists (1 Toronto, 1 Saskatchewan)
 - 1 psychiatric nurse (Saskatchewan)
 - 1 clinical dietitian (Saskatchewan)
-
- ⇒ all 5 had current or past male clients with anorexia or bulimia

Appendix U

Profile of Male Eating Disorder Participants

| PARTICIPANT | DESCRIPTION |
|--|--|
| (42 yrs) •initial interview | <ul style="list-style-type: none"> • anorexia and bulimia • referred to the researcher through a health professional • current and active psychiatric treatment |
| (36 yrs) •initial interview •follow-up interview | <ul style="list-style-type: none"> • bulimia • referred to the researcher through a health professional • no treatment |
| (21 yrs) •initial interview | <ul style="list-style-type: none"> • anorexia • referred to the researcher through a health professional • past dietetic counseling |
| (mid-20s) •initial interview | <ul style="list-style-type: none"> • bulimia • self-referred • no treatment |
| (18 yrs) •initial interview | <ul style="list-style-type: none"> • anorexia • referred to the researcher through a health professional • past psychiatric treatment and counseling |
| (21 yrs) •initial interview •follow-up interview | <ul style="list-style-type: none"> • “anorexia” - disordered eating • referred to the researcher through a health professional • not diagnosed; at the very early stages of the ED • current counseling (other issues) |
| (21 yrs) •initial interview •follow-up interview | <ul style="list-style-type: none"> • bulimia • referred to the researcher through one of the other participants • no treatment • past counseling (other issues) |
| (mid-30s) •initial interview | <ul style="list-style-type: none"> • anorexia • referred to the researcher through a health professional • current and active psychiatric and medical treatment |

Appendix V

Resources Specific to Males and Disordered Eating

Note: This is simply a list of the resources that were found through the resource search. They have not been evaluated by the researcher for accuracy, appropriateness, or applicability for males with eating disorders. Therefore, this list should not be considered as the researcher's recommendations for the best resources; rather, it gives an idea of the types of resources that might be available.

1) **“My Life as a Male Anorexic” (book)**

Krasnow, M. (1997). My Life as a Male Anorexic. New York: The Haworth Press Inc.

contact: Haworth Canada
450 Tapscott Road, Unit 1
Scarborough, ON M1B 5W1
Phone 1-800-342-9678
Fax 1-800-895-0582

- The story is written like a diary, chronicling his ongoing struggles with anorexia and co-morbid psychiatric diagnoses. The author tells about his feelings and experiences, what his life is like, and how the eating disorder has affected and controlled his daily life.

2) **“Adolescent and Adult Males with Eating Disorders: Some General Facts” (fact sheet)**

Saskatoon Interagency Committee on Eating Disorders

contact: Public Health Services
310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This fact sheet contains information on clinical manifestations of AN and BN, body image issues, predisposing factors, and general awareness.

3) **activity kit (untitled)**

contact: Youth Health Promotion Unit
Yukon Government

Box 2703
#2 Hospital Road, Rm. 112
Whitehorse, Yukon Y1A 2C6
Phone (403) 667-8894 (office of the minister)
Fax (403) 667-8424 (office of the minister)

- A one day activity combining workshops on body image, nutrition, personal care, what it is to be male, and rock-climbing activities. Its purpose is to foster a sense of self, particularly with respect to identifying pressures on young men to look and behave in certain ways and how these pressures are counterproductive to learning about feeling good about oneself. It is composed of a slide show of male and female body types shown in media and implied behavioral expectations on men and women based on images. Facilitators lead discussion on masculinity.

4) **“Men with Eating Disorders” (bulletin)**

Woodside, D.B. (1993). Men with eating disorders. National Eating Disorder Information Centre Bulletin; 8(5): 1-3.

contact: National Eating Disorders Information Centre
200 Elizabeth St.
CW 1-211
Toronto, ON M5G 2C4
Phone (416) 340-4156
Fax (416) 340-4736

- Discusses eating disorders as they affect men. Contains information on incidence, symptoms, treatment, and comparing males and females with eating disorders (social factors, sexual orientation, willingness to access treatment).

5) **“Eating Disorders in Gay Men: Current Issues” (bulletin) - National Eating Disorder Information Centre (1997)**

Cohen, M. (1997). Eating Disorders in Gay Men: Current Issues. National Eating Disorder Information Centre Bulletin; 12(3): 1-4.

contact: National Eating Disorders Information Centre
200 Elizabeth St.
CW 1-211
Toronto, ON M5G 2C4
Phone (416) 340-4156
Fax (416) 340-4736

- Discusses eating disorders as they affect gay men in particular. Contains information on issues of vulnerability, presentation of eating disorders, the focus on appearance in the gay subculture, and what can be done to help gay men with eating disorders.

6) **“Muscle: Confessions of an Unlikely Bodybuilder” (book)**

Fussell, S.W. (1992). *Muscle: Confessions of an Unlikely Bodybuilder*. Avon Books.

- This book was referred to this research as a resource on body image issues in men. Reviews of this book describe its content as an insight on the psychology of obsession and how it can shape a man's character. It discusses one man's initiation into the world of professional bodybuilding.

7) **“Males with Eating Disorders” (book)**

Andersen, A.E. (Ed). (1990). Males with Eating Disorders. New York: Brunner/Mazel.

contact: Saskatchewan Health Resource Library
3475 Albert St.
Regina, SK S4S 6X6
Phone (306) 787-3090
Fax (306) 787-3237

- Topics covered include body image concerns of men, treatment of eating disorders, influences on the development of AN and BN, and comparing males and females with eating disorders. It is written from an academic point of view, reviewing some literature and medical knowledge about eating disorders in males.

8) **“Body Image: Why are so many young men turning to steroids to change their bodies? What can we do about it?” (pamphlet)**

9) **“Using Steroids” (pamphlet)**

10) **“The Steroids and Body Image Project: Teacher's Guide” (manual)**

11) **“Steroids Make you Smaller” (poster)**

12) **steroids and health (untitled) (poster)**

- Items 8 - 12 are part of **“The Steroids and Body Image Project”** by the Canadian Centre for Ethics in Sport. Its goal is to educate young men about the dangers of steroid use. The target group for use is those who have key influence on body image - health professionals, parents, coaches, and teachers. The target for the messages is young men between the ages of 14-20. It is composed of two

pamphlets, one on steroid use and one on body image, and two posters geared to body image and its relationship to steroid use. As well, there is a teacher's guide containing lesson plans on steroids and body image.

contact: The Canadian Centre for Ethics in Sport
1600 James Naismith Dr., Suite 702
Gloucester, ON K1B 5N4
Phone (613) 748-5755 or 1-800-672-7775
Fax (613) 748-5746

13) "Adolescent Males and Eating Disorders" (fact sheet)

Body Image Resource Kit, Saskatchewan Health

contact: Public Health Services
310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This fact sheet is targeted towards grade 7 and 8 boys. It discusses general information on body image in adolescent males, awareness of eating disorders in males, and influencing issues.

14) "Steroid Use and the Teenage Male" (pamphlet)

Body Image Resource Kit, Saskatchewan Health

contact: Public Health Services
310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This pamphlet is targeted towards grade 7 and 8 boys. It discusses reasons for using steroids, risks of steroid use, facts on the effects of steroids, and who to contact for further information.

15) support group for gay males with eating disorders - Toronto Hospital

contact: Dr. Miles Cohen email - mcohen@istar.ca
#1509-2 Carlton St.
Toronto, ON M5B 1J3
Phone (416) 593-0233
Fax (416) 593-9336

- This psychoeducational group operates on a six-week commitment by members. At the time of the research, the group was in its third week of the first program. It operated on the premise that males like to know that they are not the only one struggling with an eating disorder, and common experiences would foster a sense of comfort and belonging.

Appendix W

Non-Gender Specific or Combination Resources That Can Be Used For Males and Disordered Eating

Note: This is simply a list of the resources that were found through the resource search. They have not been evaluated by the researcher for accuracy, appropriateness, or applicability for males with eating disorders. Therefore, this list should not be considered as the researchers recommendations for the best resources; rather, it gives an idea of the types of resources that might be available.

1) “Body Image Resource Kit”

contact: Public Health Services
310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This is a kit that is used by health educators in Saskatchewan. It contains videos, magazine ads, posters, pamphlets, fact sheets, resource books, and lesson plans on eating disorders, body image, and self-esteem. Each public health nutritionist in Saskatchewan has a kit for use by teachers, health professionals, and other community leaders for classroom instruction and/or programs intended to prevent eating disorders and promote healthy body image.

To arrange for loan of the kit, contact the public health nutritionist for your area.

2) “Beyond the Looking Glass” (video)

Part of the “Body Image Resource Kit”

contact: Public Health Services
310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This video focuses on issues related to adolescents. It is for use by health professionals and educators with groups of high school students. It features adolescents of a variety of ages, ethnicities, backgrounds, and genders, talking about their experiences and how they handle difficult issues. The goal is to promote self-esteem and confidence, and to provide some skills for dealing with social pressures and issues. The video comes with a facilitator’s manual containing questions and discussion activities to encourage audience participation.

3) “Vitality Leader’s Kit”

contact: Health Canada

Health Promotion and Programs Branch
15th Floor, Jeanne Mance Building
Postal Locator 1915A
Ottawa, ON K1A 1B4
Phone (613) 954-8549
Fax (613) 954-7363
e-mail - nhrdpinfo@inet.hwc.ca

- This is a kit for use by health professionals and educators for the purpose of promoting vitality and healthy living. The kit contains fact sheets on healthy body image, self-esteem, physical activity, and smoking and weight. There are also statistics and research information on healthy living. Many of the sheets are for making overheads for the purposes of a presentation. There are also activities, such as quizzes, for use with audiences during presentations.

4) “Real People with Eating Disorders” (video)

contact: Saskatchewan Health Resource Library

3475 Albert St.
Regina, SK S4S 6X6
Phone (306) 787-3090
Fax (306) 787-3237

- This video chronicles three people’s struggles with eating disorders. Two women (one anorexia, one bulimia) and one man (binge eating disorder) tell their personal stories of an eating disorder, how it affected their health and lives, and what they did to overcome it. The video also features some general information about the three eating disorders for educational purposes.

5) “Kids of Today” (manual)

contact: Public Health Services

310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This program was designed collaboratively by a number of health education professionals. The goal is to prevent the development of eating disorders through addressing factors such as self-esteem, body image, and weight preoccupation. It is a manual for health professionals and educators geared for

grades 6-7 boys and girls. The program contains activities, and information on building a healthy sense of self, feelings, the body, relationships with food, family, personal relationships, school environment, media, healthy eating, and gender socialization.

6) “The Eating Edge: A Guide to Healthy Eating for Teens” (manual)

The Ontario Milk Marketing Board (1992)

contact: The Ontario Milk Marketing Board
6780 Campobello Road
Mississauga, ON L5N 2L8

available from: The Saskatchewan Dairy Foundation
2-425 Winnipeg St.
Regina, SK S4R 8P2

- This is a manual for use by teachers, health educators, and dietitians for use with grade 9 and 10 students. The program’s goal is to enable adolescents to develop the necessary skills to make personalized healthy food choices in an ever changing environment. Lessons include activities on identifying influences on food intake, comparing intake with Canada’s Food Guide, setting realistic nutrition goals, and identifying personal motivators. Opportunity for discussion on media, body image, and influence of family and friends.

7) “5-Day Lesson Plan”

Levine, M. & Hill, L. (1991). A 5-day Lesson Plan Book on Eating Disorders: Grades 7-12. National Eating Disorders Organization (Laureate Psychiatric Clinic and Hospital).

contact: Public Health Services
310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This is a set of lesson plans for teachers for educating students about eating disorders. Lessons include the effect of culture on body image, media and body ideals, set-point theory of weight, awareness about eating disorders, and how to help someone with an eating disorder. The goal is to provide teachers and health educators with a set of ready-to-use tools to encourage discussion on eating disorders and contributing factors.

8) “Heads UP” (video)

Part of the “Body Image Resource Kit”

contact: Public Health Services
310 Idylwyld Dr. North
Saskatoon, SK S7L 0Z2
Phone (306) 655-4620

- This video discusses body image and self-esteem issues and is targeted towards the aboriginal population.

9) support and education groups

10) treatment programs

11) counseling services

- The availability of these groups and services (items 9-11) needs to be researched on a local basis. Contact your local public or community health centre or individual health professionals you know.

12) Bridgepoint Center for Eating Disorders

contact: Bridgepoint Center for Eating Disorders
Box 190
Milden, SK S0L 2L0
Phone (306) 935-2240
Fax (306) 935-2241
e-mail - bridgepoint@sk.sympatico.ca

- Bridgepoint is a non-profit organization providing support and services to individuals with eating disorders. They offer a variety of programs, including interim residential rehabilitation, relapse prevention weekends, peer support retreat weekends, integrative follow-up services, awareness and education, and resource/information center.

13) Montreaux Clinic

contact: Montreaux Eating Disorder Counselling Centre
Box 5460
Victoria, BC V8R 6S4

- Montreaux is a rehabilitative clinic for individuals with eating disorders. They offer residential treatment programs for anorexia and bulimia.

Appendix X

List of Internet Sites with Information on Males and Eating Disorders

Note: This is simply a list of the resources that were found through the resource search. They have not been evaluated by the researcher for accuracy, appropriateness, or applicability for males with eating disorders. Therefore, this list should not be considered as the researchers recommendations for the best resources; rather, it gives an idea of the types of resources that might be available.

1) **<http://www.primenet.com/~danslos/males/links.html>**

- This site provides over 20 links to other related sites containing information about males and eating disorders. Some of the sites are articles about specific issues and topics, and others are linked to support centres. As well, this site provided links to personal stories of males who have had eating disorders.

2) **<http://www.something-fishy.com/ed.htm>**

- This site provides links to information on various aspects of eating disorders. For example, there is information available on managing stress, physical dangers, prevention, and family and friends. There are opportunities for other links to related sites; as well, there are links provided for on-line support and chat-lines. Most of the information here is not male specific; however, there is a link provided to access male specific information.

3) **<http://www.mirror-mirror.org/eatdis.htm>**

- This site provides links to specific information about various aspects of eating disorders. For example, there is information available on the signs and symptoms of eating disorders, finding a therapist, set-point theory, and children with eating disorders. Most of the information here is not male specific; however, there is a link provided to access male specific information.

4) **<http://www.columbia.edu/cu/healthwise/0339.html>**

- This page offers a question and answer (“Dear Abby” style) about a male with an eating disorder.

5) **<http://www.primenet.com/~danslos/males/resources.html>**

- This page offers lists of journal articles, magazine articles, newspaper articles, and books related to males and eating disorders. Also offers links with

personal stories, chat rooms, and other resources.

- 6) **<http://www.usatoday.com/uwire/co031309.htm>**
 - This page offers an article entitled, “Do I Look Fat in This Shirt?”
- 7) **<http://www.mentalhealth.com/mag1/p5h-et01.html>**
 - This page offers an article entitled, “Male Anorexia.”
- 8) **<http://www.mentalhealth.com/mag1/p5m-et01.html>**
 - This page offers an article entitled, “Despite Image, Most Anorexics Are 45 or Older.”
- 9) **<http://www.medscape.com/Medscape/Mental.../v02.n04/mh3060.braun/mh3060.braun.html>**
 - This site offers a medical article on eating disorders in males. It is part of Medscape, an on-line medical research reference system. The article discusses which males develop eating disorders, treatment and outcome, and the types of eating disorders (anorexia, bulimia, compulsive overeating). This page also provides a reference list of readings related to eating disorders in males.
- 10) **<http://www.mhsource.com/edu/psytimes/p950942.html>**
 - This page offers an article entitled, “Eating Disorders in Males.”
- 11) **<http://www.mhsource.com/edu.psytimes/p950942.html>**
 - This page offers an article entitled, “Eating Disorders in Males”
- 12) **<http://www.zeusnet.com/bjblinder/anmales.htm>**
 - This page offers an article entitled, “Anorexia in Males.”
- 13) **<http://www.zeusnet.com/bjblinder/atpmales.htm>**
 - This page offers an article entitled, “Atypical Eating Disorders in Males.”
- 14) **<http://www.zeusnet.com/bjblinder/blmales.htm>**
 - This page offers an article entitled, “Bulimia in Males.”

- 15) **[wysiwyg://bottom.35/http://www.uq.edu.au/~zzedainc/n3index.html](http://www.uq.edu.au/~zzedainc/n3index.html)**
- This site is the home page for the Eating Disorders Resource Centre. It offers links to chat rooms, personal stories, pen pals, and general information about eating disorders. Most of the information is not male specific; however, some of the stories are of males who struggle with eating disorders.
- 16) **<http://www.press.umich.edu/TitlesS95/goldstein-male.html>**
- This page offers an article entitled “The Male Body.”
- 17) **<http://www.columbia.edu/cu/healthwise/hw32.html>**
- This page offers an article entitled, “The Male Body: Is Rambo our Best Choice?”
- 18) **<http://spc.syr.edu/seriously/departments/disorders.html>**
- This page offers an article entitled, “Man in the Mirror.”
- 19) **<http://www.bucknell.edu/bucknellian/sp96/04-18-96/lifest/5575/html>**
- This page offers an article entitled, “The Overlooked Ten Percent.”

Note: Many of these sites will not only give you specific information on males with eating disorders, but will connect you with other sites offering on-line support groups, personal stories and testimonials, links to non-profit eating disorders organizations, and information about treatment programs.