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Portfolio Submitted for the Award of

Doctorate in Counselling Psychology (DPsych)

‘Examination of hidden realities through practice and reflection: a journey towards integrating several levels of reality’

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Dedication

For you dad, the kindest and smartest man that I have ever known. You knew this reality was possible for me before I knew it myself.

For all people and things that remain unseen and unacknowledged.

DECLARATION

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

PREFACE

This portfolio combines three pieces consisting of an original qualitative research, that investigates the experiences of males with eating disorder symptoms, a combined case study and process report based on a psychodynamically informed work, and a publishable paper. Together, these share a common theme: 'examination of hidden realities that leads to integration'. These works represent my professional development as a trainee counselling psychologist, as they demonstrate the integration of the academic, clinical, research, and personal elements necessary for me to become a well-rounded and ethical professional. All these pieces are discussed below in relation to this theme and to my training development.

Section A: Qualitative Research

This section consists of a qualitative study investigating experiences of males with eating disorders (EDs). I first became interested in exploring this topic owing to my personal experiences, not with EDs, but through my awareness of the link between eating behaviours and body image in terms of how one relates to themselves and the world, and an overall curiosity about EDs, due to witnessing this happening to someone else. However, it was the significant marginalisation of males with ED symptoms revealed in the initial stages of this research that really motivated me to pursue this subject further.

For these reasons, this research aimed to raise awareness of ED in males and increase the possibility of EDs becoming a more accepted reality for men. Eleven males diagnosed with an ED were interviewed and shared their experiences in relation to symptom identification, treatment, recovery, and interpersonal contexts. The data were analysed using an inductive Thematic Analysis based on Braun and Clarke's (2006) procedure, underpinned by a critical realist paradigm.

The emergent themes further fuelled my interest and commitment to raise awareness in this population, as they demonstrated that participants not only faced a marginalisation within the ED field, but also faced a marginalisation regarding their experiences with EDs' symptoms. The themes highlighted that men associated EDs with females due to beliefs linked to gender norms ideals. Additionally, ED symptoms were experienced paradoxically, consisting of both positive and negative meaning, some of which were also associated with gender norms ideals.

As a result, most males struggled to identify their symptoms as ED symptoms, which led to varied descriptions in their journey towards symptom identification, help-seeking, treatment, and recovery. Thus, revealing deeper structures at play, such as the influence of sociocultural norms, in generating and maintaining restrictions on men's agency regarding their experiences with EDs' symptoms.

Moreover, participants also attributed their alienation from EDs to a lack of information about ED in males, which consequently inhibited them from sharing their ED experience with others, especially other males; thus, they did not feel EDs were part of a male's reality. Nevertheless, the visibility of EDs in other males was described as reducing their sense of isolation and increasing the validation of EDs as part of a man's experience. Thus, the ability to view an ED as a possible reality in another male led to an integration of their lived experience of symptoms as men with EDs.

Therefore, the findings demonstrate the importance of being seen for this population and of considering, reflecting, and further investigating sociocultural processes to which all of us subscribe in our personal and professional lives, such as gender norms, that potentially restrict the agency of males experiencing ED symptoms. Thus, this research renders more visible the reality of EDs in males and helps equip health professionals and other males experiencing ED symptoms with the knowledge to achieve this.

This study is also a call for action to challenge current structures maintaining the marginalisation of males with EDs in the hope of increasing their agency within the ED world. As such, it focuses on a stratified reality proposed by the critical realist paradigm that assumes some aspects of reality are neither obvious nor directly accessible. Accordingly, the hidden realities associated with participants' experiences can only be revealed through participants' reports and the meanings they ascribe to them. It was through the investigation of such meanings that these were revealed.

Hence, in the context of my development as a counselling psychologist, this research enhanced my awareness of the need for reflection on the multiple realities associated with participants' experiences and indeed my own, including underlying realities such as sociocultural processes of which we are all a part. This only became possible by combining or integrating reflection (about self, participants, and the world) with theory, which aligned with my counselling psychology training. Thus, I further developed my ability to think dialectically within a counselling psychology ethos (Woolfe, 2016), which means being open to several worldviews and ideas whilst remaining grounded in ethic and congruence. This was achieved by following the research paradigm and methodology, positioning participants as the experts on their experiences, and considering my own role in understanding and participating in such realities.

Furthermore, the wish to promote awareness in this population and reduce gender inequality within the ED field prompted by this research also aided my development as a trainee and, hopefully, future professional due to its alignment with the counselling psychology ethos of promoting social justice (Kasket, 2012). This is because it highlighted my impact as an active agent, and also that of sociocultural contexts, on people's experiences. This indicates the need to go beyond addressing individuals in therapy and instead consider, reflect, and act on broader sociocultural aspects that might generate and restrain people's agency.

Section B: Combined Case Study and Process Report

This section consists of a combined case study and process report that represents a psychodynamically informed work with a client who wanted to improve her relational patterns. It represents an attempt to integrate the client's good and bad objects, while I endeavoured to integrate several levels of meanings associated with the psychological modality, the client's manifested and latent meanings, and the use of my own self. This work represents a significant aspect of my development as a trainee counselling psychologist due to the reflection required whilst working with this client. The psychoanalytical model required me to identify what aspects related to the client's experiences and what aspects related to my own whilst thinking about the theory, helpful ways to intervene, and our therapeutic alliance, all of which felt very challenging.

Consequently, some of the material during the session was sometimes left unnamed as I did not want to damage our therapeutic alliance. However, supervision sessions and personal therapy allowed me to reflect on my practice and helped me to identify personal processes during the sessions with the client. This identification of processes that were not obviously known to myself was what enabled me to improve in the following sessions, as this helped me to become more open about my own processes with the client and also to identify more clearly materials that related to me, her or us. This in turn enabled the client and I to identify her underlying feelings of anxiety, allowing what remained hidden to surface and to become acknowledged. Thus, reflective practice enabled hidden realities to be identified, named, talked about, and incorporated in a way that improved my therapeutic relationship with the client and the client's relationships with self and others. Therefore, it was through the challenges demonstrated in this work that growth took place for both me and my client.

Accordingly, this combined case study and process report further illuminates the overall examination of hidden realities that leads to integration, due to the use of psychodynamics and its parallel with critical realism's notions of stratified realities (conscious and unconscious), where not all realities are readily accessible, but which can be revealed through actions and reflections about such actions (Pilgrim, 2017). Thus, it was only through reflection on my own processes, client processes, sociocultural aspects, and theory that integration of all these aspects became possible, but in a way that was ethical and supportive, as they were aligned with the client's worldviews and goals (Willig, 2019). Thus, the deep and broad reflection required in the work with this client represents a stepping stone in my development as a trainee counselling psychologist.

Section C: Publishable Paper

This section consists of a journal article based on the qualitative research presented in section A which will be submitted to the journal *Psychology of Men & Masculinities*. The choice was driven by the journal's interest in disseminating advances in the psychology of men and masculinities and the impact of sociocultural constructions of gender on boys' and men' lives. Additionally, the journal welcomes papers focusing on mental health and employing qualitative methodologies, and is also interested in work from the counselling psychology field.

The article highlights the main themes that emerged in the qualitative research that were associated with males' experiences with EDs and their association with gender roles. It also elucidates the impact of the marginalisation of males identified in the ED research and on their experiences of symptoms, and suggests areas for further research and how to improve practice to better serve this population. This paper will add to the current ED research on males and ensure this field becomes more integrated with respect to gender by increasing male representation within the ED field.

Furthermore, the journal article aligns with the overall theme: 'examination of hidden realities that leads to integration', as the publication of this article will help reveal the hidden and marginalised reality of these participants and potentially of other males with EDs. This hopefully can generate reflection on this topic, the population, and potential causes maintaining such marginalisation, serving to initiate action to address such causes.

All three sections reflect my personal, academic, clinical and research development as a trainee counselling psychologist, as they encompass several crucial aspects that had to be reflected upon and integrated, thereby increasing my ability to reflect in a manner that is ethical, congruent, and fosters growth.

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SECTION A: QUALITATIVE STUDY

‘Men in a woman’s world: experiences of eating disorders in men’

Ligia Larissa Pinheiro

Supervised by Dr Jacqui Farrants

ABSTRACT

Background: Notwithstanding the increasing number of males experiencing eating disorder (ED) symptoms, and consequently the higher number of males with EDs expected to require clinical attention, there is a lack of ED research focusing on males and even fewer studies focusing on their experiences beyond treatment and recovery. Also, there is a lack of research employing qualitative methodologies and investigating males displaying symptoms of binge-eating disorder (BED). Therefore, this study aimed to explore males' experiences beyond treatment and recovery and to include males with BED, in addition to anorexia nervosa (AN), and bulimia nervosa (BN). Methods: This study employed a qualitative methodology underpinned by a critical realist paradigm. Eleven men in the UK, diagnosed with AN, BN and BED, were interviewed and the data were analysed using an inductive Thematic Analysis (TA) based on Braun and Clarke's (2006) procedure. Results: Four main themes emerged from the data: 'EDs don't happen to people like me', 'EDs as paradox', 'Steps for change', and 'EDs are not part of men's reality.' These findings suggest that men's experiences of their symptoms were strongly associated with sociocultural norms pertaining to gender roles. Also, the findings and limitations were discussed with regard to clinical practice, such as highlighting the need for healthcare professionals to consider and challenge sociocultural norms associated with ED and gender, and suggestions for further research to investigate males from diverse backgrounds, sexualities and ages. Conclusions: Gender ideals within an ED context should be challenged to improve gender equality in ED research and in clinical contexts.

LIST OF ABBREVIATIONS

AN	**Anorexia Nervosa**
APA	American Psychiatric Association
BED	Binge Eating Disorder
BN	Bulimia Nervosa
CBT	Cognitive Behavioural Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
EDNOS	Eating Disorders Not Otherwise Specified
EDs	Eating Disorders
FPT	Focused Focal Psychodynamic Therapy
FT	Family Therapy
GT	Grounded Theory
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Approach
MANTRA	Maudsley Anorexia Nervosa Treatment for Adults
MD	Muscle Dysmorphia
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OSFED	Other Specified Feeding or Eating Disorders
SSCM	Specialist Supportive Clinical Management
TA	Thematic Analysis

1. CHAPTER ONE: LITERATURE REVIEW

1.1 Introduction

In this chapter, I review qualitative literature on the experiences of males with EDs by first defining the main EDs and then presenting an overview of ED research in males. This synopsis highlights a historical under-representation of males within ED research, affecting symptom recognition and treatment among males and the impact of stigma and gendered norms on these aspects. The review also draws attention to the lack of qualitative ED research involving males and the dearth of qualitative reviews exploring males' experiences beyond treatment. I critically review qualitative literature on males with EDs from the last decade, including studies that focus on experiences beyond treatment, highlighting their contribution to understanding males' subjective experiences and current gaps in the literature. Finally, I emphasise the importance of addressing such gaps and how the current study aims to achieve this.

1.2 Literature Review

1.2.1 Definition of EDs

EDs are severe mental disorders defined by repetitive and disturbed eating behaviours that threaten physical, mental, and social wellbeing (APA, 2013). Among other mental disorders, EDs have the highest mortality risk (Smink et al., 2012; van Hoeken & Hoek, 2020) and are estimated to affect over 1.25 million individuals in the UK (Beat, 2017), 25% of whom are expected to be males (Sweeting et al., 2015). However, despite seminal works describing AN in males and the severe negative impact of EDs on overall wellbeing (APA, 2013), most ED research to date has focused solely on females (Murray et al., 2017).

This study focuses on the main EDs defined by the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-V; APA, 2013): Anorexia Nervosa (AN), characterised by significantly low body weight, distorted perceptions of body shape or weight, and '*intense fear of weight gain or of becoming fat, or persistent behaviour that interferes with weight-gain'* (APA, 2013, p. 338); Bulimia Nervosa (BN), characterised by short periods of binge-eating followed by compensatory behaviours to avoid weight gain, such as excessive exercising and purging; and Binge-Eating Disorder (BED), characterised by binge-eating (eating significantly large amounts of food) associated with a lack of control and accompanied by guilt, disgust, and depressive symptoms. Finally, symptoms that do not fully meet the above criteria are defined as Other Specified Feeding or Eating Disorders and Unspecified Feeding or Eating Disorders (APA, 2013) or Eating Disorders Not Otherwise Specified (EDNOS) in previous versions of the DSM (APA, 1994).

1.2.2 Overview of EDs in males

A broad search of the literature from the last decade identified two literature reviews on ED in males. These comprehensive reviews (Jones & Morgan, 2010; Murray et al., 2017) highlighted several key areas relevant for this population and are presented below to provide an overview of current knowledge about ED in males.

Prevalence

The prevalence and severity of EDs are known to be significantly higher in females than males (Duncan et al., 2017; Ulfvebrand et al., 2015). Nevertheless, current research suggests that EDs are estimated to affect 25% to 33% of males instead of the often stated 10% (Murray et al., 2017). Also, males display a high incidence of ED behaviours (Mitchison et al., 2014), and ED risk factors such as body dissatisfaction (Mitchison & Mond, 2015). Additionally, gay males might display high rates of body dissatisfaction (Bosley, 2011), suggesting a higher ED risk among this group (Jones & Morgan, 2010). However, studies on broader sexual and gender presentations are lacking (Gorrell & Murray, 2019). Male athletes have also been considered at high risk for EDs owing to engagement in ED-associated behaviours such as extreme dieting and exercising (Nagata et al., 2020; Pila & Gorrell, 2021).

ED Measures and Symptoms

Despite this alarming evidence and the potentially severe negative impact of EDs on overall well-being (APA, 2013), ED symptoms in males might go under-recognised and untreated, which can lead to higher ED severity in this population (Strother et al., 2012). A significant reason for is that historically, ED research has primarily focused on female samples, which has marginalised males from the development of ED measures (Striegel-Moore & Bulik, 2007), diagnosis, and treatment (Murray, Griffiths, & Mond, 2016).

Consequently, the most common measures used to assess ED symptoms, such as the Eating Disorder Examination (EDE; Fairburn & Cooper, 1993), EDE-Questionnaire (EDE-Q; Fairburn & Beglin, 1994), and Eating Disorders Inventory (Garner et al., 1983) were developed based on female ED experience (Darcy & Lin, 2012; Striegel-Moore & Bulik, 2007). This is problematic for males because despite sharing many similarities with females regarding ED symptoms (Jones & Morgan, 2010), research indicates that males might be more likely to display behaviours targeted at muscle gain instead of weight loss, the latter of which is more strongly associated with females (Allen et al., 2013; Darcy et al., 2012). Also, when compared with females, males are more likely to attempt suicide and exhibit co-morbidity of mental disorders (Bramon-Bosch et al., 2000), have later ED onset (Crisp, 2006), report fewer body concerns, and be overweight prior to ED onset (Fernandez-Aranda et al., 2009). This constitutes a varied range of aspects that seem to differentiate males from females with EDs.

For these reasons, some measures have been developed to capture the way EDs might manifest in males (e.g., ED Assessment for Men; Stanford & Lemberg, 2012; Drive for Muscularity Scale; DMS; McCreary & Sasse, 2000; Male Body Image Concerns Scale; Weisman et al., 2014). However, notwithstanding their high reliability and validity in assessing ED symptoms in males, they have been employed less frequently with males than the traditional female-centric measures (Darcy & Lin, 2012).

Notably, the latest version of the DSM (APA, 2013) removed amenorrhea as an AN criterion and included 'behaviours that hinder weight gain' instead of 'behaviours aimed at weight loss', reflecting some consideration of how symptoms might manifest in males. However, it has been argued that the DSM-V (APA, 2013) criteria for EDs still fail to consider behaviours that could be relevant for males, such as drive for muscularity and exercise; instead, these are criteria for muscle dysmorphia (MD), a subtype of body dysmorphic disorder, but MD does not focus on eating behaviour (Murray et al., 2010).

Consequently, this might perpetuate the lack of ED symptom recognition and subsequent treatment in males (Smith et al., 2017). This highlights the fact that males' experiences of ED symptoms are largely absent in the medical criteria for EDs. This can affect males' access to treatment, as the use of standardised measures is recommended for an ED diagnosis (NICE, 2017), albeit not solely but in addition to other indicators associated with changes in body, behaviours, and social life.

Treatment

The literature examining treatment has reported that males with EDs are offered shorter treatments than females (Striegel-Moore et al., 2000), are more likely to withdraw from therapy (Aguera et al., 2017; Støving et al., 2011), and more inclined to engage in treatment avoidance (O'Dea & Abraham, 2002), which can lead to symptom deterioration and poor prognosis

(Strother et al., 2012). Also, males with EDs might be further marginalised by the hospital guidelines established in 2010 in the UK which require same-sex inpatient wards. This is because most inpatient settings do not have male wards due to the lower prevalence of males with EDs compared with females; consequently, services would need to adjust their settings, such as providing separate rooms for males. However, such changes can be limited by financial constraints, resulting in an additional difficulty for males wishing to access inpatient help for EDs (Fukutomi et al., 2018).

Stigma and gender roles

Moreover, treatment avoidance in males has been associated with an unwillingness to discuss emotions and health concerns (Schlichthorst et al., 2016; Yousaf et al., 2015), adherence to rigid gender roles (Rogers et al., 2001; Ridge, Emslie, & White, 2011) – defined as a set of cognitions, attitudes and behaviours that are socially agreed to represent genders (such as norms of power, emotional and physical control, and dominance representing traditional Western masculine ideals; Connell, 1995) – and beliefs that EDs affect only females, which can be stigmatising for men (Griffiths et al., 2014).

Stigma has been defined as a multi-faceted social process, commencing with the attribution of labels by the general population to socially constructed human differences, such as medical conditions, and then adding stereotypes to those labels (negative beliefs/attributes). This creates a clear distinction between the group doing the labelling and the group being labelled, ultimately resulting in exclusion (Link & Phelan, 2006).

As a result, associating EDs with the female gender (Griffiths et al., 2014) appears to have led to ED being labelled as a female disorder, which is then perceived by males as negative and, therefore, stigmatising. This negative connotation has been attributed to gender being considered a system of power relations, where historically men have created and maintained power over women and male minorities. Consequently, adherence to norms of hegemonic masculinity and its resulting disassociation with female' ideals in general are aimed at maintaining power and social status for dominant groups of males (Messner, 1997).

Additionally, research has revealed several additional labels that have been attributed to EDs by the general population; for example, that they are the result of a weakness of character (Ebneter et al., 2011), lack of discipline (Ebneter & Latner, 2013), and are self-inflicted (Roehrig & McLean, 2010). Furthermore, when comparing genders, males were found to hold more stereotyped beliefs about EDs than females, such as perceiving them to be less serious disorders (Anderson et al., 2016; Griffiths et al., 2014; McLean et al., 2014; Rodgers et al., 2015; Simpson & Mazzeo, 2017).

In addition, ED stereotypes and the marginalisation of males with EDs have also been identified in wider contexts beyond an individual's beliefs, such as in the UK media. Sweeting and colleagues (2015) suggested that the incidence and prevalence of EDs among males in the community could be 15% higher than the figure portrayed by media, while MacLean and colleagues (2015), in an examination of articles released by UK newspapers between 2002 and 2012, found that EDs were presented as a female disorder and that information about EDs in males was associated with shame, less masculine men, and was a disorder not recognised by professionals.

MacLean and colleagues' (2015) study also stated that in 2008 there was a peak in articles regarding EDs in males as a result of MP John Prescott revealing his BN experience, which initially could be seen as favourable in raising awareness about this issue. However, the authors argued that some articles associated John Prescott's experience of BN with females and also used a mocking tone, e.g., *'John Prescott is the Princess Di of politics'* (MacLean et al., 2015, p. 5), while other articles argued that it was courageous for a man to reveal such topic. This demonstrates that stereotypes associated with EDs and gender are reinforced by cultural contexts.

Especially worrying is the fact that clinicians, including psychologists, were also found to hold stigmatising attitudes towards EDs, such as the belief that they are self-inflicted, and male clinicians in particular reported experiencing negative feelings such as frustration when treating EDs, all which were associated with a lack of competence in this domain (Thompson-Brenner et al., 2012). These findings are troublesome and demonstrate that an increase in clinicians' knowledge could help to reduce such beliefs in healthcare providers.

Treatment

NICE (2017) proposes several types of treatment for EDs. These include ED focused cognitive behavioural therapy (CBT-ED) aimed at improving physical health and symptoms; nutritional knowledge and promotion of healthy eating; self-efficacy and monitoring eating practices and cognitions; the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA), which also considers wider social contexts; specialist supportive clinical management (SSCM), which considers individuals' agency in deciding what should be included as part of therapy; ED focused focal psychodynamic therapy (FPT), which emphasises the role of the therapeutic alliance and the meaning of symptoms for the person; and family therapy (FT) for young people, where carers adopt a central role in helping manage the ED.

However, the guidance makes no reference to differences among gender or in male populations regarding diagnosis and treatment, despite suggestions that the latter should consider gender differences in the way ED is presented in males (Blashill, 2011), such as variations in body image and weight concerns when compared with females (Strother et al., 2012), and challenge concepts and beliefs relating to masculinity that EDs affect only females (Greenberg & Schoen, 2008). Moreover, there are prospective studies exploring treatment outcomes, rendering it uncertain as to whether males need different forms of treatment compared with females as both genders have been found to benefit equally from the same CBT treatment (Strobel et al., 2019).

Nevertheless, the latest guidance on EDs in adults for UK commissioners and care providers (NHS, 2019) states that it is necessary to reduce the inequalities experienced by males and transgender people regarding symptom identification and access to treatment. Additionally, notwithstanding the body of research presented above providing invaluable information regarding males' experiences of ED symptoms, along with advances in ED research addressing males' historical marginalisation from research and treatment, little has been revealed about males' subjective experiences. This is primarily because the vast majority of ED literature in males derives from studies employing quantitative methodologies (Murray, 2021). Qualitative research could therefore help to identify evolving processes and meanings that might not be addressed in quantitative measures such as surveys (McLeod, 2015) and so provide a more in-depth understanding of ED symptoms in males. This could help to reduce the inequality evident in ED research and access to treatment experienced by males.

However, three other systematic reviews over the last decade focusing on specific aspects of ED in males, such as ED measures (Darcy & Lin, 2012), prevalence rates, clinical features, risk factors (Raevuori, Keski-Rahkonen, & Hoek, 2014), and the impact of measures on assessment and treatment (Gorrell & Murray, 2019), either did not include any qualitative study or only a very few. Among these reviews, only Raevuori and colleagues (2014) included a qualitative study. Thus, they provide little clarity on the subjective experiences of males with EDs.

Quantitative methodologies are undeniably crucial in exploring and elucidating epidemiological data, and developing measures tailored for males to improve the treatment experience and symptoms. However, such studies continue to exclude the very population they repeatedly report as being marginalised from ED research: males with EDs and their subjective experiences. By contrast, qualitative studies are suitable for generating knowledge and understanding about meanings and experiences (Daher et al., 2017), which is paramount in improving our comprehension of such experiences among males with EDs (Delderfield, 2018).

Consequently, reviews exploring treatment experience (Richardson & Paslakis, 2021; Shanga, 2019; Thapliyal & Hay, 2014; Thapliyal, Hay, & Conti, 2018) offer more insight into males' subjective experiences. For example, the most recent systematic review exploring males' experiences of ED treatment, conducted by Richardson and Paslakis (2021), examined 9 qualitative studies and identified four main themes: symptom recognition, help-seeking, treatment features, and patient features. This study described several aspects identified by previous quantitative research, such as lack of ED information and knowledge acting as a barrier to treatment and help-seeking. Also, the perception of ED as a female disorder and its association with being emotional and fragile did not match males' experiences of EDs due to sociocultural perceptions of gender roles.

In particular, the review highlighted how males experienced feelings of wanting to be understood during treatment, exhibiting a preference for non-judgemental therapists and person-centred approaches. It was also helpful in highlighting how some males experienced conflicting emotions in perceiving the ED both as a solution and as a problem. The authors concluded that health professionals should improve their knowledge of EDs in males, and that services should recognise the treatment needs of males with EDs.

Findings from other reviews focusing on treatment and including qualitative studies (Shanga, 2019; Thapliyal & Hay, 2014; Thapliyal, Hay, & Conti, 2018) are extremely similar to those described above, as most included the same primary studies as Richardson and Paslakis (2021) in their reviews, while others also included studies with female samples (Thapliyal et al., 2018) or studies that did not specify participants' ED diagnoses (Shanga, 2019; Thapliyal & Hay, 2014; Thapliyal et al., 2018). Additionally, due to their focus on treatment and recovery, these reviews only included studies focusing primarily on the treatment experiences of males. This meant they did not elucidate males' experiences beyond treatment.

Yet such knowledge could be helpful in understanding how EDs might affect males' experiences more broadly, equipping healthcare professionals with information that could be helpful in tailoring interventions and treatment specifically to males' needs. For these reasons, the following review expands current reviews on treatment experiences by incorporating qualitative studies that explore males' subjective experiences of other aspects of their lives beyond treatment and recovery.

1.2.3 Literature Review of Qualitative studies

Selection Method and Criteria

This review included English language articles published in peer-reviewed journals from 2010 to 2021, obtained from APA PsycINFO, Medline, Web of Science and Google Scholar databases using the following keywords: men OR man OR males OR male OR boy OR boys AND eating disorder OR bulimia, anorexia OR binge-eating disorder. The inclusion criteria were that the studies needed to include samples consisting of males diagnosed with an ED and to have employed qualitative methods of inquiry.

Furthermore, to limit the search parameters and the scope of this review, articles focusing on obesity or muscle dysmorphia (MD, defined as self-perceived body flaws resulting in anxiety and isolation; APA, 2013) were excluded, despite being similar to ED and affecting a high proportion of males (Allen et al., 2013; Kessler et al., 2013). Also, articles that neither included nor specified formal ED diagnoses (e.g., Arnow et al., 2017; Dearden & Mulgrew, 2013) were excluded. Following this process, and after inspecting abstracts and removing duplicates, 14 articles remained.

Perceived causes of EDs

Among the studies selected, some highlighted causes and risk factors for males with EDs that are described as associated with the onset of their disorder. For example, Wallin and colleagues (2014) interviewed 15 males aged between 19 to 52 years who had recovered from AN, BN, or EDNOS and were from Norway and Sweden. Focusing specifically on the perceived causes of EDs, they organised their findings into three themes: lack of self-satisfaction, family environment, and external events. The participants reported attempts to address self-dissatisfaction, such as a drive to perform well academically and improve body image and self-esteem by exercising and dieting, as associated with ED onset. Participants also described family problems, such as feeling isolated and high family expectations, and external events such as being bullied at school, moving homes, and comparing body image to others and the media, as associated with the onset of their ED. This demonstrates that males perceived wider social, economic, and cultural contexts to be associated with the onset of ED symptoms

In another study, Leichtman and Toman (2017) interviewed 6 men in the US aged between 21 to 60 who recovered or were recovering from AN or EDNOS. These participants described low self-esteem regarding their body image and a lack of self-confidence as associated with the onset and maintenance of their EDs. However, this study did not specify participants' individual EDs, which meant no comparison could be made among participants in terms of ED subtypes. Nevertheless, this study highlights some of the more personal aspects males associated with their ED symptoms.

Although there was a difference in the mean age of participants in both of the studies described above (Wallin et al, 2014 and Leichtman & Toman, 2017; 23 and 40, respectively), the described age of ED onset was very similar (between 10 and 21 years of age and 9 to 20 years approximately, as the information was not clearly reported in the second study). This is congruent with a review of older males with AN, BN, BED and EDNOS – with ages ranging from 40 to 81 years (mean age 58 years) – which found that ED onset happened earlier in life for most males (Reas & Stedal, 2015). However, the review found that some males only sought treatment later in life, which they attributed to a lack of ED identification by the males themselves, clinicians, and family, or resistance to seeking therapy for reasons such as the stigma associated with EDs. This emphasises that the lack of ED recognition not only by males but also several others indicates that EDs are not readily recognisable in males and pinpoints the role of stigma in determining whether males seek help.

In another study, Boon, Zainal and Touyz (2017) interviewed 4 males in Singapore aged between 20 to 33 years with AN, BN, or BED, and found that they reported body dissatisfaction associated with excess weight as responsible for triggering their EDs, while some males associated body concerns with the fact they were gay. This study was the only one reviewed that investigated Eastern males and one of the few that included males with BED. Therefore, it helped in providing insight into the experiences of males from diverse backgrounds regarding their perception of the causes of EDs, echoing findings from studies involving Western samples. However, the small sample size did not allow the themes to reach saturation in their analysis, meaning that more insight could be gained into the experiences of Eastern males. This indicates that more research employing males from diverse sociocultural backgrounds is needed.

Nevertheless, these findings are congruent with previous research findings on ED aetiology and risk factors in straight males and gay males, and highlight the influence of self-esteem and external factors such as social contexts, family problems (Tylka, 2021), and body dissatisfaction as risk factors for EDs (Mitchison & Mond, 2015; Bosley, 2011).

However, Wright and colleagues (2016) examined the causes of EDs in boys and found that body dissatisfaction was not reported as a primary cause (Wright, Halse & Levy, 2016). These findings appear to contradict the proposed negative influence of external factors such as media and peers on body satisfaction among adolescent boys (McCabe et al., 2015). Also, they are not congruent with claims that the adolescence period is a potential ED risk factor for males due to hormonal, psychological, and neurological changes and social contexts such as the influence of peers (Eisenberg, Neumark-Sztainer & Paxton, 2006).

This period has also been identified by Calzo, Austin and Micali (2018) as a risk for boys from sexual minorities, as bisexual and gay boys in the UK reported higher body dissatisfaction compared with heterosexual boys. However, this study consisted of a small sample, as the authors conducted interviews with 6 boys (and also their mothers) aged 9-13 in Australia who were diagnosed with an ED, and an analysis of interviews from a previous study, which examined the experience of EDs within a sociocultural context. Thus, a larger sample and interviews focusing specifically on body (dis)satisfaction could have explored in greater depth the role of body dissatisfaction in causing the onset of EDs in boys.

Furthermore, the specific EDs of boys were not reported (the study only mentioned that participants had been diagnosed with an ED and were recruited from two ED specialist centres). Therefore, this study does not allow for comparisons among ED subtypes, offering somewhat broad conclusions regarding boys' perceptions of their bodies. Nevertheless, the authors highlighted the importance of considering other potential causes of EDs in young males, rather than generalising findings from older male populations to this group.

Symptom recognition and treatment-seeking barriers

Several studies have offered insights into males' experiences of symptom recognition. For example, Pettersen, Wallin and Björk (2016) analysed the same sample as Wallin and colleagues (2014) described above, and found that some males recognised that had a problem when they realised that weight, food, and body image controlled most aspects of their lives, impairing their relationships and their ability to study and work.

In another study, Robinson and colleagues (2013) explored the various experiences of living with an ED, including treatment-seeking and treatment experience, among 8 men in the UK currently receiving ED treatment for AN, BN or EDNOS. They found that several males reported that perceptions of EDs as a female disorder formed a barrier to symptom recognition. This finding was replicated in Thapliyal and colleagues' (2020) study, which explored treatment experiences among 8 men in Australia with either AN or BN, and Räisänen and Hunt's (2014) study, which explored symptom recognition and help-seeking among 10 men in the UK with a current/historical ED diagnosis of AN, BN or EDNOS.

Additionally, the males in Räisänen and Hunt's (2014) study reported ED information focusing only on females, a lack of ED awareness, and dismissal of symptoms by family and clinicians (which they attributed to their male gender) as barriers to symptom recognition, resulting in diagnostic delays for some and misdiagnoses of depression or gastrointestinal problems for others. Similarly, Lyons and colleagues (2019) explored the lived experiences and ED impact on 7 men in the UK diagnosed with AN or EDNOS-AN and found that they recognised their symptoms as those of an ED only after a GP's diagnosis.

The findings from these studies might represent males diagnosed with AN, BN or EDNOS in more depth, as the samples in these studies were highly similar. However, no men with BED were interviewed; therefore, it is unclear how males with BED might experience symptom recognition. This is important given the high prevalence of BED in males (MacCaughelty et al., 2016) and the perception among clinicians that BED is less severe than other EDs (Reas, 2017). Additionally, findings indicating that males with BED might report lower shape and weight concerns than females with BED, and that males in general might not report such concerns at the beginning of their ED treatment, suggest clinicians should consider such differences when treating males, particularly males with BED (Shingleton et al., 2015).

Also, three of the studies examined males in the UK and one in Australia, the mean age of participants varied from 20 to 38 years, and most males were White and heterosexual. Thus, experiences of symptom recognition of older straight males, gay males, and males from diverse backgrounds were not explored. Nevertheless, these studies illuminated males' experiences of minimising their ED symptoms due to its association with masculine ideals of remaining in control of the weakness associated with EDs (Thapliyal et al., 2020) and the shame associated with having an ED, which was also due to perceiving it as a weakness that did not conform with masculine ideals of strength (Lyons et al., 2019).

These findings are congruent with previous research suggesting that the stereotype of ED as a female disorder can be stigmatising for males with EDs (Griffiths et al., 2014), and clinicians perpetuate the stigma associated with EDs in males (McNicholas et al., 2016). Also, they echo studies suggesting that males in particular are at greater risk of not having ED symptoms diagnosed and treated (Griffiths et al, 2015a) due to negative attitudes and beliefs, such as being perceived 'less of a man' (Griffiths et al., 2015b) and suggestions that men adhering to rigid gender roles have difficulty acknowledging they need help (Rogers et al., 2001; Ridge, Emslie & White, 2011; Shepherd & Rickard, 2012). This further emphasises the need to target the impact of gender norms on stigma in the general population and also clinicians due to its negative impact on ED diagnosis and treatment.

Males also reported additional barriers to treatment-seeking, such as the perceived benefits of EDs, which include food and eating as a way to cope with negative emotions and cognitions (Leichtman & Toman, 2017; Robinson et al., 2013), the euphoria and sense of victory resulting from food restriction (Leichtman & Toman, 2017), and also the fear of disclosure due to expectancies others would respond negatively (Robinson et al., 2013). Therefore, it is not surprising that Boon, Zainal and Touyz (2017) found that help-seeking in their sample was motived by comorbidity issues, such as mood disorder or addiction, or initiated by participants' parents rather than the recognition of ED symptoms.

Treatment-engagement

While males in another study by Thapliyal and colleagues (2020) reported the predominant presence of females in treatment settings as significant barriers to engaging in treatment, resulting in experiences of isolation and lack of validation, participants in Boon and colleagues' (2017) study described fear of gaining weight as a barrier to engaging in treatment. However, despite research demonstrating males' preference for muscular body ideals (Allen et al., 2013), focused specifically on the chest and arms (Dakanalis et al., 2012), this finding is still congruent with evidence suggesting that males with EDs tend to focus not only on muscle-gain but also on leanness (Jones & Crawford, 2005; Klimek et al., 2018).

Moreover, it is important to note that in males, muscle dissatisfaction and disordered eating aimed at muscle gain were found to be associated not only with conformity to masculine norms, such as emotional control and self-resilience, but also with conformity to feminine gender norms, such as being sweet and friendly and happier with a thinner body (Griffiths et al., 2015c). Thus, the author suggested that both gender norms should be discussed when treating males with EDs and that it was important not to assume males striving for muscular ideals necessarily subscribe to masculine gender norms.

However, there is also evidence suggesting that AN is viewed as more feminine than muscle dysmorphia (Griffiths et al., 2014), whereas BED is seen as more masculine (O'Connor et al., 2016). While this reflects the high prevalence of BED in males (MacCaughelty et al., 2016) and AN in females (APA, 2013), it also reflects assumptions surrounding behaviours and body shape and size relating to gender, which in turn could be stigmatising for women with BED (binge-eating perhaps resulting in high weight is not seen as feminine) and men with AN (slim body and restricting food is not seen as masculine).

These studies not only highlight the interplay between gender norms and body ideals but also the role of the physical body within the context of EDs. Delderfield (2018), for example, examined the experiences of males with ED symptoms in-depth and discussed the meaning attributed to the effect of these symptoms on men’s bodies as representing a way to relate to themselves, others, and the world. For instance, men described ED behaviours as a way to modify the body, such as decreasing body fat, in order to meet sociocultural ideals, resulting in positive reactions from others and avoiding negative ones. Fat for some of these participants did not represent manliness, consequently the body represented an inadequate way to exist in the world as a man.

Therefore, EDs were discussed not as phenomena happening to the body, but as a manifestation of the body, due to complex relationships with ones’ past history, and the view of oneself and others. As such, EDs in the context of the body are associated with a multitude of deeper and more complex social, economic, cultural, and familial structures. Moreover, the author highlighted the importance of conducting further research into males’ experiences of fat, body, and the impact of masculinity gender norms on these aspects.

Additional factors males reported as relevant for engaging in treatment were having their experiences with ED symptoms validated by professionals (Robinson et al., 2013), a good relationship with therapists and the acquisition of skills targeted at symptom reduction (Leichtman & Toman, 2017). Similarly, Thapliyal and colleagues (2017) examined 6 published autobiographies of males in the US diagnosed with AN, BN or BED, and found that perceiving healthcare professionals as non-judgmental and empathic, other patients as friendly, trusting the therapist, and learning new skills helped males during treatment. However, the study identified mixed preferences regarding therapists' style, as some preferred more rigid therapists while others preferred more caring therapists where issues were slowly discussed. Similarly, regarding the therapy setting, some preferred group therapy due to feeling a sense of empathy and normalisation of behaviours from others in the group, while others preferred the anonymity of individual therapy.

Additionally, Thapliyal and colleagues (2020) reported that participants found it helpful to have therapists that were experts in EDs, and who were non-judgmental and empathic during treatment. Agency in wanting to improve symptoms was also reported as aiding treatment engagement by the males in this study. Kinnaird and colleagues (2019) interviewed 14 UK men diagnosed with AN, BN, BED, or EDNOS, and found that they would prefer ED materials to be less female oriented and more neutral, and also to display more examples of EDs in males within the material rather than in exclusive sections. Additionally, the researchers' findings regarding the gender of staff were mixed, as some males expressed a preference for a higher male representation within the staff, while the majority reported satisfaction with being treated by female therapists. Similarly, some found group therapy with a majority of females unhelpful, as they did not feel it addressed their issues as males, while others found it helpful.

Therefore, the findings suggested that males would welcome ED materials that were more gender-neutral and displayed more examples of males with EDs. Also, some males suggested incorporating more ED experiences among males into group discussions to avoid reinforcing the belief that ED is a female disorder and feelings of isolation among males. This is congruent with suggestions that roles and pressures associated with masculinity are relevant for males with EDs during treatment (Bunnell, 2016; Greenberg & Schoen, 2008; Russell & Laszlo, 2013).

Thapliyal and colleagues' (2020) study also reported mixed findings regarding males' preference for group therapy and the gender of other patients in the group; one participant mentioned that having another male in treatment reduced his sense of isolation as a male with an ED and also as a straight man (due to a belief that ED is a feminine disorder). By contrast, others reported that group therapy with other males resulted in competitiveness among males regarding ED behaviours (i.e., weight-loss). Additionally, some participants mentioned that they felt they disclosed too much or too little, which impacted their treatment experience.

Consequently, the authors concluded that masculine norms of competition and withholding personal problems affected participants' treatment experiences. They highlighted the importance of discussing the role of masculinity norms during group therapy as a means of providing a safe space for males to openly share issues associated with their EDs. Additionally, this study also highlighted other stereotypes associated with EDs, such as ED only affecting males who are gay, which could impair the treatment experience for some straight males.

Unhelpful treatment strategies

Lyons and colleagues (2019) found that most participants in their study did not report difficulties in being diagnosed by their GPs and being referred to treatment, although some mentioned long waiting times which they associated with the quality of provision of ED services in the area in which they lived (also known in the UK as a post-code lottery). Also, some participants mentioned the treatment's primary focus on weight restoration, as opposed to focusing on mental aspects, as unhelpful, as they felt they still needed psychological help. In addition, most men reported dissatisfaction with the representation of men by ED charities, stating ED information was still female-centric. The authors also suggested some men were discriminated against during treatment in terms of facilities, such as a lack of toilets for males, lack of information tailored for males, and feeling isolated in a majority female group.

Regarding gender in ED treatment, some males described finding the availability of treatments tailored to individual needs more critical than treatment being tailored to males (Leichtman & Toman, 2017). Similarly, Kinnaird and colleagues (2019) found that males did not think their gender was relevant during treatment but would find treatment focusing on their individual needs helpful. Nevertheless, most felt excluded due to the preponderance of female patients and professionals in their treatment settings.

Other unhelpful aspects of treatment reported by some males were a lack of expertise and judgmental attitudes among professionals, feeling excluded by professionals and female patients because of their male gender, and either expecting too little or too much from treatment (Thapliyal et al., 2017). Similarly, Thapliyal and colleagues (2020) found that not feeling understood by healthcare professionals and a lack of treatment catering specifically for the needs of men with EDs led to feelings of isolation and an inability to voice concerns.

The authors suggested that ED knowledge needs to increase in the general population and healthcare professionals so that treatments catering for the specific needs of men with EDs can be developed. Additionally, some participants in Lyons and colleagues (2019) study reported that their ED behaviours were more under control while living with the family. Thus, the authors suggested that the family could be acting as a protective factor for some men or that participants were hiding ED behaviours from them, which would result in symptoms increasing in severity over time.

Similar to this finding, a study by Brown and colleagues (2021) examined the impact of EDs on 9 females and 1 binary person during the COVID-19 lockdown in the UK, which restricted people from going out of the house in an attempt to limit the spread of the virus. They found that for some, the presence of others such as a partner at mealtimes (i.e., which would otherwise have taken place at work), meant it was harder to perform ED behaviours such as skipping meals. Conversely, for others, staying at home led to increased under-eating due to the absence of others during meals, as when they were in the presence of others there would be a perceived expectation that one should eat larger amounts of food to avoid judgement. This suggests that the expectancy of judgement due to the presence of others might make it more difficult to perform ED behaviours.

Recovery

Some qualitative studies specifically focused on males' recovery experiences. Pettersen, Wallin and Björk (2016), for example, reported several aspects men experienced as helpful for their recovery, such as the realisation they had a problem, physical recovery, good relationship with therapists, being able to understand and verbalise their needs, relating to others in different ways such as distancing themselves from unhelpful relationships, mourning the loss of the ED, distancing their sense of self from the ED, and agency in wanting to improve ED symptoms. Agency was also highlighted as a necessary aspect for recovery in a study by Lyons and colleagues (2019).

Recovery was described by males in Björk and colleagues' (2012) study as the ability to eat and exercise in balanced ways, including controlling the compulsion to exercise and body acceptance. However, although some participants reported feeling fully recovered from their EDs, others felt they would always struggle with food and exercise-related thoughts.

In a study conducted by Lewke-Bandara, Thapliyal, Conti, and Hay (2020), recovery was experienced in similar ways by 8 men from New Zealand, Australia, and US, aged from 20 to 33 years, who were diagnosed with AN or BN. The researchers found that participants perceived recovery as the ability to eat foods they had not eaten before, increased self-awareness, and improved relationships with others. An increase in self-awareness, ED triggers, and improved interpersonal relationships were also described as a sign of recovery in another study by Leichtman and Toman (2017).

Furthermore, males in Thapliyal and colleagues (2020) study associated recovery with the absence of worrying and feeling anxious about ED related issues, such as body concerns and bingeing and purging behaviours. However, the males in this study did not think they were fully recovered, even in the complete absence of ED symptoms, and reported the availability of continued support after recovery as helpful. They also mentioned that gaining knowledge and skills to deal with triggers was crucial in maintaining their recovery. This study demonstrates that recovery can mean different things for different people. Therefore, clinicians should explore the meaning of personal recovery when treating males with EDs.

Working experience

Regarding working experience, most men reported difficulties navigating work with an ED, including stress, decreased working performance (Lyons et al., 2019), and fears employers could find out they had an ED (Robinson et al., 2013). This was also confirmed by a very recent study specifically exploring the working experiences of males with EDs by Siegel and Sawyer (2020), who interviewed 14 men with AN, BN, and BED in the US. They found that most males did not disclose their EDs in the workplace as they did not want to be perceived as weak or less masculine and feared repercussions.

Moreover, most participants reported high stress and anxiety for feeling as men that they could not talk about their feelings. However, some of the men who disclosed their ED at work felt it helped their recovery. Additionally, some men reported that it was easier to disclose their ED to other women than men, and in terms of coping strategies at work, most men hid their ED behaviours, tried to blend in, used humour, or left their jobs. Most men also reported feeling they were not performing well at work. According to the authors, men’s pressure to conform to masculine ideals significantly impacted how they managed their ED in the workplace. To the best of our knowledge, this is the only qualitative study to date to specifically explore the workplace experiences of males with EDs. Therefore, it provides vital knowledge about the negative impact of EDs in other areas of males' lives beyond treatment and recovery settings, highlighting the need to address their experiences of ED within broader social settings.

1.2.4 Limitations

All the literature described above has provided invaluable insights into the experiences of males with EDs and highlighted several difficulties faced by this population regarding symptom recognition, treatment, and workplace. The review has also illuminated how these aspects are associated with conformity to masculine gender norms and negative beliefs and attitudes linked to EDs. Unfortunately, however, most studies did not include a diverse sample, as most participants were white and heterosexual males, apart from Boon and colleagues (2017) who recruited males in Singapore, and Raisanen and Hunt (2014) who included one Latino and one Mixed race participant.

Another issue is that some studies included conditions not classified as EDs; for instance, Leichtman and Toman (2017) included morbid obesity, while others did not specify the EDs of individual participants (Wright et al., 2016). Most studies employed semi-structured interviews, which allows in-depth exploration, apart from Thapliyal and colleagues (2017) who examined published biographies and Wright et al. (2016) who analysed interviews conducted in a more extensive study. Also, out of the 14 studies reviewed, only 4 considered males with BED (Boon et al., 2017, Thapliyal et al., 2017; Kinnaird et al., 2019; Sigel and Sawyer, 2020). This highlights the need for more qualitative studies on males with BED.

Additionally, most of the studies focused on treatment and recovery experiences, and only three focused on broader aspects of men's experiences (Leichtman & Toman, 2017; Lyons et al., 2019; Robinson et al., 2013). However, none of these three studies included males with BED, and the first two studies did not include males with BN, further emphasising the need to explore the experiences of males with BED. Moreover, several studies examined the same sample of males (Björk et al., 2012; Pettersen et al., 2016; Wallin et al., 2014, which openly declared the use of a shared sample), while Thapliyal and colleagues (2020) and Lewke-Bandara and colleagues (2020) did not openly declare the use of the same sample, but the demographic characteristics of the participants were identical. This reduces even further the number and diversity of males with EDs represented in qualitative research.

In conclusion, this review highlighted a remarkable lack of qualitative studies within the ED literature on males. Moreover, within the qualitative literature, most studies focused on treatment and recovery; very few focused on broader aspects of the lives of males with EDs beyond treatment and recovery. Also, few studies investigated all the main ED presentations: AN, BN, and BED, in the same sample. Thus, the experiences of males with EDs within broader life contexts remain obscure, especially males with BED. For these reasons, the current research explores men's experiences beyond treatment and recovery and includes males with BED. In so doing, it provides a more in-depth understanding of the lived experiences of males with EDs and a platform from which this under-researched population can voice their experiences.

1.3 Relevance to Counselling Psychology

The current research contributes to Counselling Psychology by providing rich and valuable information to better understand a population that has been under-researched and often misunderstood by healthcare professionals (Strother et al., 2012; Arnow et al., 2017). More research must be conducted on males with ED symptoms to increase our current understanding of their subjective experiences and how these affect their wellbeing and agency in the world. In so doing, males with EDs, the general population, and healthcare services and professionals, including psychologists, will better understand males' experiences and the potential challenges that arise.

In turn, these will address suggestions that healthcare services in the UK do not appropriately cater for the needs of males with EDs (Copperman, 2000), which is important given predictions that clinicians are expected to see an increasing number of males with EDs in their practices (Murray et al., 2017). This research will therefore contribute to informing future ED research in males, and will continue to increase our knowledge about this group.

Furthermore, given that an increase in ED knowledge with respect to males has been suggested to help to reduce the stigma associated with EDs (Bannatyne & Stapleton, 2015), the resulting knowledge generated by this research will address a need already identified by Petrie and Rogers (2001), who urged Counselling Psychologists to recognise and deal with stigma specific to men with EDs. Finally, this research strives to promote social justice, which is of high relevance to Counselling Psychology research (Kasket, 2012), by providing a platform for a marginalised population within the domain of EDs to voice their experiences and hopefully feel a sense of increased agency.

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2. CHAPTER TWO: METHODOLOGY

2.1 Introduction

The previous chapter highlighted the lack of ED research in males, particularly research utilising qualitative inquiry that would provide an in-depth investigation into the experiences of males with EDs, increase knowledge about this marginalised group in the wider field of ED research, and equip professionals and other males with information to better understand this population. Therefore, this chapter describes the methodology and methods that served as a basis for this research. Firstly, the research paradigm will be presented, including a discussion of the ontological and epistemological positions adopted. This is followed by an outline of the methodology adopted, the rationale for this choice, and a discussion of alternative approaches. Finally, the research procedures are described and ethical considerations discussed.

2.2 Research aims and questions

This research aimed to provide an insight into males' experiences and understanding of their EDs by exploring the way in which they deal with identifying symptoms, seeking treatment, recovery, and navigating interpersonal contexts (with family, friends, work, healthcare professionals). The research questions were as follows:

- What are males' experiences of their ED symptoms?
- How do males make sense of their experiences?

2.3 Research Paradigm

A research paradigm guides the research methodology and methods in order to produce sound, ethical, and reflexive research (Hitchcock & Hughes, 1995). Guba and Lincoln (1994) define a paradigm as the worldviews held by an individual, which includes their beliefs and assumptions about the nature of the world, their place within it, and ways of relating to it. Additionally, a research paradigm accounts for the type of relationship developed between the researcher and the participants (Coghlan & Brydon-Miller, 2014).

As such, understanding the researcher's worldview, beliefs as to what constitutes reality (ontological assumptions) and concerns regarding how such reality can be known (epistemological assumptions), are fundamental in clarifying the choice of methodology and methods most suited to addressing the research questions (Denzin & Lincoln, 2011). Methodology can be described as a systematic way of doing research and includes the rationale behind the methods chosen to explore the research question (Kothari, 2004), while methods can be described as the techniques employed to collect and analyse data (Hitchcock & Hughes, 1995).

The current study adopted a critical realist approach characterised by ontological realism and epistemological relativism (Archer et al., 1998: xi). There are two extreme ontological stances, realism and relativism, and two extreme epistemological stances, positivism and relativism. Realism asserts that a reality exists independent of the human mind, while relativism asserts that reality is constructed according to the subjective meaning ascribed to it (Coghlan & Brydon-Miller, 2014). Furthermore, positivism asserts that the real world can be known through observation and measurements, while relativism denies the existence of an observed, measurable reality, instead acknowledging a reality that is dependent on the observer (Pernecky, 2016).

Personally, I believe in the existence of a real world independent of human perception that existed prior to me being born and will continue to exist after my death, thus implicating a realist ontology. However, I also believe that reality can only be known through our experience of it; it cannot be assessed directly, hence reflecting a relativist epistemology. My belief in a realist ontology and relativist epistemology places me in a critical realist position (Willig, 2013).

Over time, critical realism has had several philosophical positions and contributors, which might differ slightly but all adopt a post-positivist philosophy, thereby accepting the influence of other variables in perceiving reality (Archer et al., 2016). Critical realism was first introduced by Roy Bhaskar, who suggested reality is layered and composed of empirical, actual, and real aspects (Maxwell, 2012). The empirical aspect refers to experiences of events, the actual layer refers to all events that exist, whether experienced or not, while the real aspect refers to mechanisms that cause the events, such as the physical and social worlds (Houston, 2001).

Another key concept associated with critical realism is human agency. This is the ability to reflect on the world and make choices; however, human agency is understood to be influenced and also limited by mechanisms at play within an individual and the world (natural and social world), such as the body, as well as past and current events (Pilgrim, 2020).

However, critical realism also accepts that people are not passive in the face of such influences and instead possess the agency to transform their reality and are transformed by it in return (Houston, 2001). Moreover, critical realism also considers the social and cultural contexts that might influence one’s perception of reality and views mental phenomena and meaning as real, as opposed to abstractions or social constructions (Maxwell, 2012).

Therefore, in the context of this study’s paradigm, ED as diagnostic criteria would not refer to a reality belonging to Bhaskar’s real layer of reality, but to the empirical layer, as mental health disorders would be considered a socially constructed theory based on clinical accounts of symptoms (Johnstone & Boyle, 2018). This implies that EDs are understood in terms of people’s experiences of behaviours (i.e., eating, not eating, exercising, purging), body (i.e., low weight for AN), negative emotions (i.e., fear of gaining weight, guilt after eating), and cognitions (i.e., altered perception of the body size and shape) along with others (APA, 2013) that have been theorised as belonging to a diagnosis of ED.

This indicates that ED diagnosis per se does not constitute an independent reality. However, that is not say that symptoms (which have been socially constructed as ED symptoms and medically categorised as ED criteria) are not real, as they have several consequences for those experiencing them, even death in the case of AN (van Hoeken & Hoek, 2020). Therefore, the ED symptoms in this study are considered to be events (which constitute Bhaskar's actual layer of reality) that are experienced by people (in their empirical layer of reality).

It also demonstrates that the experience of symptoms theorised as EDs can be experienced in multiple ways by people, and that the real layer of reality, which comprises the multiple structures at play giving rise to such symptoms, such as those theorised by biopsychosocial models of ED development (i.e., biological and psychological predispositions, such as genetic and trauma, and the role of social contexts; Nagata et al., 2021) cannot be directly measured (Bhaskar & Danermark, 2006). Consequently, this study investigated participants' empirical reality with respect to their ED symptoms and assumed that the mechanisms underplaying such experiences can only be interpreted through their accounts of such experiences.

Mental health diagnoses are underpinned by positivist medical models that view mental health disorders as a real entity happening to people and which diverge from the philosophy adopted in this study, as described above. However, despite this consideration, the ability to work with mental diagnostic criteria is also an essential part of the role of counselling psychologists, as it leads to shared understanding among professionals and in relation to treatment (Woolfe, 2016). Additionally, a dialectical way of thinking is encouraged during counselling psychology training, exemplified by the requirement to be proficient in two psychological modalities that might hold conflicting philosophical bases and principles. This implies that critical thinking and an ability to engage in subjectivity and appreciate unique and diverse personal meanings, worldviews, and social contexts plays a necessary and fundamental role in enabling practice and theory to be integrated congruently (Woolfe, 2016).

For these reasons, this study accepts that researcher and participants will have a shared understanding of EDs as mental diagnosis criteria (as this was required for participants to have received an ED diagnosis). Yet such diagnosis criteria will be considered by the researcher as a theory, rather than a reality in itself. In this way, this research remained rooted within the counselling psychology humanist philosophy by engaging with participants' subjectivity and considering their personal meaning and worldviews while retaining an awareness of social contexts, discrimination, and empowerment (BPS, 2005).

Moreover, it is critical to recognise that the knowledge produced by a critical realist paradigm is not a direct reflection of participants' reality, as the data inevitably undergoes a process of interpretation through the researcher's perceptions of their experiences (Willig, 2012). This highlights the importance of reflexivity throughout this research, which is discussed in detail later in this chapter.

Therefore, by exploring the reality of males' experiences relating to their EDs (by assessing their empirical layer), the aim was to develop a better understanding as to which aspects could be associated with agency constraints, which then can be used to increase people's agency, including that of males with EDs, in changing contexts (i.e., increased ED research and awareness of EDs among males in healthcare contexts).

For example, Archer (1995) explains that people are part of a pre-existing economic, political, social, and cultural reality (mechanisms composing the real critical realism layer). Thus, in the context of EDs in males, their marginalisation in ED research, as highlighted by the literature review, might act as a historical mechanism that can contribute to EDs being attributed less to males than females (real layer). This can then lead to discrimination in medically diagnosing males (events, which constitute the actual layer), which can in turn act as constraints on males' agency in accessing treatment.

Thus, uncovering such knowledge might help in questioning the practices and contexts that could be restraining the agency and wellbeing of males with EDs. This aligns with critical realism's emphasis on uncovering mechanisms to promote agency and change (Houston, 2001). This leads to a secondary goal of this study, which is to encourage participants to gain or increase awareness of the meaning they ascribe to their experiences and also the perceived causes of their EDs (Pawson, 1996).

2.4 Methodology

2.4.1 Research Design: Qualitative research versus Quantitative

Critical realism supports several methods of research depending on the aims and questions of the study. As explained in the literature review chapter, there is lack of research exploring males with EDs and most of the literature that does exist has employed quantitative methodologies. Therefore, quantitative ED research assumes a positivist stance that relies on the use of measures to access knowledge about males. These have mostly been designed based on females' experiences of EDs, which also indicates an assumption of a direct access to reality (Coolican, 2014).

Nevertheless, it is important to recognise that such quantitative research has also contributed to the field of ED in males, and the contribution of both quantitative and qualitative research into understanding phenomena are welcomed within the counselling psychology field (Rafalin, 2010).

Yet the fact remains that most quantitative ED research in males has utilised measures based on the experiences of females. Thus, adopting a qualitative methodology can improve our current understanding of males with EDs and provide the knowledge that has perhaps been lacking in quantitative studies using pre-established measures that cannot account for new forms of meaning (Malterud, 2001). Also, a qualitative methodology aligns with the critical realist position adopted, as it accepts that participants' reality can only be accessed through their experiences (Bhaskar, 1997). Consequently, a qualitative enquiry is expected to deliver a broader and deeper level of understanding and knowledge (McLeod, 2011) regarding the experiences of this population.

For these reasons, to investigate men's experiences of having an ED in alignment with the philosophical research paradigm adopted, it is necessary to move away from the positivist derived quantitative methodologies that focus on pre-established variables, and instead focus on participants' meanings using a qualitative methodology of inquiry (Willig, 2008).

Additionally, a qualitative methodology also considers and values the role of the researcher (Coolican, 2014) and of reflexivity (Day, 2012) during the research process. This also aligns with my critical realist position and my training as a counselling psychologist, as it considers my interpretation of participant's experiences to be part of the research process.

2.4.2 Thematic Analysis Rationale

To reduce my influence on the data and remain loyal to participants' experiences, an inductive Thematic Analysis (TA) was employed to analyse the data. This is because an inductive TA provides a clear approach to the data through coding and generating themes, and a rich description of the data set aiming to account for the explicit meaning reported by participants (Braun & Clarke, 2006). It is also well-suited to answer the research question because of its flexibility, which aligns with my critical realist research paradigm. Additionally, its aims of organising and richly describing the data by identifying common themes, and analysing and reporting them (Braun & Clarke, 2006) to produce rich data, are congruent with the qualitative methodology informing this research.

According to McLeod (2011), TA originated from grounded theory, which seeks to generate a new theory from data by describing and conceptualising participants' experiences; while others suggest TA originated from content analysis, which seeks to interpret and code the data (Braun & Clarke, 2016). However, a critical realistic TA is interested in understanding how participants make sense of their experiences and how social contexts might impact those meanings, as well as acknowledging individuals' agency and the restraints associated with such realities (Braun & Clarke, 2006). It also acknowledges that the meanings participants ascribe to their reality are fallible (Maxwell, 2012). Consequently, participants' experiences of reality might offer competing views of the same issue (Fletcher, 2017), which in turn can generate a body of data that reflects the richness of diversity among participants.

2.4.3 Alternative methods of analysis considered

Alternative methodologies such as grounded theory (GT) and interpretative phenomenological approach (IPA) were both considered in the initial design stages of this research.

2.4.3.1 Interpretive Phenomenological Analysis

IPA philosophical foundations are based on phenomenology, which strives for a deep and detailed investigation of human experiences, and on hermeneutics, which refers to the interpretation of experiences (Shinebourne, 2011). IPA also considers the role of the researcher and preconceived theories and biases in making sense of participants' experiences (Smith et al., 2009). Similarly, my critical realist position and research aims are also targeted at accessing the meaning of participants' realities whilst considering the role of the researcher. The topic I am exploring is also under-researched, and IPA is suitable for investigating under-researched phenomena (Willig, 2008). Additionally, like TA, IPA usually collects data from semi-structured interviews and organises it into themes (Smith et al., 2009).

Moreover, IPA also considers the influence of the body on the experience of oneself and the world, as our interaction with the latter is made possible through our embodied experiences (Smith et al., 2009). This is in line with critical realism's consideration of the body as an actual event and is relevant for this research due to the role of the body as a social instrument and as context for EDs events.

However, the idiographic standpoint of IPA, which is concerned with individual experiences (Smith et al., 2009), does not account for heterogeneity in participants' experiences (Willig, 2008). This means that although the current research is also concerned with individual experiences, IPA would not account for a diverse range of participants with EDs who exhibit differences in diagnosis (AN, BN, and BED) and experiences (diverse ED onset period, diagnosis, treatment, etc.).

Conversely, the use of TA allows for the identification of patterns of meaning in both shared and unique experiences among participants (Maguire & Delahunt, 2017), which renders it more appropriate. Furthermore, IPA does not attempt to explain experiences in relation to other variables not directly associated with the immediate experience being explored (Wertz, 2011). By contrast, a critical realistic TA would account for the heterogeneous sample included in this study and is interested in reporting and making sense of how other variables such as social influences might affect the meaning participants ascribe to their experiences (Braun and Clarke, 2006). Therefore, IPA was not deemed appropriate for the current research.

2.4.3.2 Grounded Theory

GT was also considered as a technique for analysing the data. GT was developed by Glaser and Strauss in 1967, and its principles are based on making sense of a social reality in new ways, and creating a theoretical model based on the data without any pre-established theoretical assumptions (Glaser & Strauss, 1999). To date, several versions of GT exist, ranging from realist to social constructivist (Birks & Mills, 2011).

A critical realist GT would have to follow a number of requirements, such as accepting that there are several ways of knowing and aiming to identify mechanisms that underlie events as opposed to a description of events (Oliver, 2012). It thus aims to produce knowledge that is concerned with identifying causes in order to bring future change. Furthermore, the GT concepts that originate from an initial analysis of the data are then used to explore the rest of the data to ensure they are representative of the claims they are making (Glaser & Strauss, 1967). This theoretical comparison of concepts (between those emerging from data and existing concepts) aims to increase the focus on the mechanisms (actual experiences) rather than the empirical; therefore, the end goal is to remove the concepts from individuals' accounts as far as possible (albeit they originated firmly in the data; Looker, Vickers, & Kington, 2021).

Moreover, GT is more traditionally concerned with inductive forms of reasoning, such as induction and abduction, which would mean approaching the data with preconceived ideas of the underlying mechanisms. This diverges from the aim of this study, which is to approach the data without a pre-existing theory to remain close to participants' accounts. Thus, a critical realist GT analysis would require active identification and coding of the empirical and actual aspects of reality embedded in participants' accounts (Looker et al., 2021), while the aim of TA in this study was to code the data at an empirical level (participants' experiences).

Thus, while a critical realist GT would be somewhat similar to the current aim of trying to understand the experiences of males with EDs, un that such an analysis would generate knowledge that would illuminate several causes associated with the marginalisation of males with EDs and undoubtedly contribute to this ED field, it departs from the aim of this study, which is primarily concerned with exploring participants' (reports of their) experiences of EDs (empirical layer), rather than a focus on the mechanisms that generate the events (actual layer) underpinning their experiences (real layer).

Therefore, the use of a critical realist TA is more aligned with the aim of foregrounding participants' experiences. However, potential aspects associated with deeper mechanisms underpinning males' experiences will be also discussed in the light of the literature. In this way, potential aspects that could be hindering males' wellbeing can be tentatively brought to light in the hope that they will be addressed and bring changes, as per the goals of critical realism (Oliver, 2012).

2.4.4 TA - methodological decisions

TA is considered a flexible method of analysis because it is not based on any theories (Braun & Clarke, 2016). For this reason, it is imperative that my research paradigm informing the research design and analysis is clear, otherwise TA might produce results that are unfocused and of lower quality (Braun & Clarke, 2006).

Braun and Clarke (2006) posed several methodological decisions that need to be considered when using TA. Firstly, it is important to determine what constitutes a theme; the current study will consider a theme any item that captures descriptions associated with males' experiences of their EDs, as opposed to items based on prevalence (e.g., those appearing in several or mostly transcribed interviews).

Additionally, Braun and Clarke (2006) acknowledge that themes will not simply emerge from the data by themselves, they will be affected by the researcher's decisions throughout the research process, which should be clearly acknowledged and reported. This gives rise to the second and third points below.

Secondly, a decision was made to provide a rich description of the dataset instead of a detailed description of a particular aspect (theoretical thematic analysis). This is because little is known about men's experiences of EDs; therefore, a bottom-up (inductive) form of analysis seems more appropriate for investigating an under-researched topic than a pre-established concept or theory (Clarke, Braun & Hayfield, 2015).

Nevertheless, it is necessary to recognise the influence of the researcher in the identification of themes, as it cannot be assumed they will emerge from the data without any intervention by the researcher (Braun & Clarke, 2006). This is aligned to the critical realism concept of knowledge being accessed only through experience (Maxwell, 2012). Thus, this inability to completely abandon the epistemological position and theories associated with the study while analysing the data has to be acknowledged and reported (Braun & Clarke, 2006). This is addressed in the post-research reflexivity considered in the discussion chapter.

Thirdly, a decision was made to identify themes at a semantic level as opposed to a latent level. A latent level implies the use of theoretical assumptions and meanings while analysing the data, while a semantic level aims to convey participants' experiences using the explicit meanings reported (Braun & Clarke, 2006). The latter is congruent with the aim of this study, which is to identify males' experiences of their EDs and how they make sense of them, as opposed to trying to explain their reality. This is achieved by identifying themes at a latent level. Nevertheless, participants' experiences described in the themes are explained in the light of the existing literature in the discussion chapter. This is also congruent with the aim of reporting themes that reflected participants' reports, thus reducing my interpretation of their experiences although, as discussed previously, it is recognised that a complete absence of data interpretation is not possible according to critical realism.

2.4.4.1 Description of TA procedure

The TA procedure followed the stages outlined by Braun and Clarke (2006):

1. Familiarisation with the data, achieved by transcribing the audio-recorded interviews verbatim and reading the transcripts several times in the search for patterns and meanings.

2. Generation of initial codes, achieved by identifying patterns in the data and labelling them.

3. Searching for themes, achieved by organising coded into potential themes while considering how codes and themes relate to one another, leading to the creation of an initial map of themes and sub-themes.

4. Reviewing themes so they are meaningful and distinct from each other.

5. Defining themes, achieved by a process of re-defining them so they represent the full scope of their meaning.
6. Reporting, by providing a written account of the data and using extracts to illustrate the argument being made in relation to the research question.

2.4.4.2 Research Quality

The limitations associated with TA are usually attributed to conducting a poor analysis (Braun & Clarke, 2006). To produce high quality research, the TA steps above were rigorously followed, along with Morrow's (2005) guidelines for assessing quality in qualitative research.

According to Willig (2008), qualitative research should be evaluated according to the study's aims and the type of knowledge it seeks to produce. This study aimed to understand how males experienced their EDs by exploring participants' accounts of several aspects of their experiences, such as identifying their symptoms, diagnosis, and treatment.

Moreover, due to the critical realism position adopted, this study also considered wider social contexts by exploring and reporting participants' relationship with wider social structures associated with their experience of EDs, such as potential triggers associated with the onset of EDS and the impact of EDs on their relationship with others. These aims were achieved by conducting a thorough TA and reporting the results in a way that reflected participants' experiences and their explanations of these

I also followed Morrow's (2005) criteria for evaluating post-positivist research to ensure high quality research was produced. These criteria are credibility (research rigour followed and communicated), transferability (can 'generalise' research claims to specific contexts), dependability (research consistent across time, analysis and researcher), and confirmability (findings representing participants while acknowledging the role of the researcher).

Credibility was achieved by ensuring reflexivity was practiced throughout the entire research process by richly describing the data and participants' experiences and their context. Transferability was achieved by reflecting on my role as a researcher and my impact on the research findings. Dependability was achieved by reporting the TA steps in detail. Finally, confirmability was achieved by reflecting on my own influence on the findings as I interpreted participants' experiences.

2.5 Methods

2.5.1 Sampling considerations

The sample comprised 11 participants, which was consistent with the aim of investigating participants’ experiences in depth as it allowed for sufficient data to identify common themes and achieve theme saturation.

The study’s inclusion criteria consisted of being male, aged 18 years old or above, in receipt of a formal ED diagnosis (current or past), and being available for an interview via video. The exclusion criteria consisted of males under 18-years-of-age and males not diagnosed with an ED. The inclusion criterion of having received a formal ED diagnosis (current or past) was devised to ensure the sample shared similar experiences of ED, rather than another disorder, and also to expand the range of participants’ experiences with regard to receiving a diagnosis and treatment, due to the literature highlighting underdiagnoses of males and consequent lack of treatment.

Additionally, if the participant was currently experiencing ED symptoms, he would have to be currently receiving professional treatment. This is because discussing current experiences in the interview could potentially elicit distress. If this was the case, participants already had a source of professional support they could rely on, in addition to the sources provided in the debrief form (see appendix A). Additionally, during the screening process all participants were asked whether they expected that talking to the researcher about their ED experiences would elicit distress. All participants answered negatively to that question.

This study was initially designed to include participants that were available for either a face-to-face or online interview. The rationale for a face-to-face interview was that it could potentially help to build a stronger rapport between the researcher and participants, while the rationale for video interviewing was to be more inclusive of participants living outside of London, as the distance could be a barrier to attending the interview in person. However, due to restrictions imposed by the COVID-19 pandemic on social distancing, interviews took place via online video only.

2.5.2 Recruitment

The study aimed to recruit a purposive sample of 10 to 12 men, which is congruent with the qualitative literature reviewed, which included samples ranging from 8 to 10 male participants. The choice of a purposive sample was to ensure sample homogeneity with respect to gender and ED diagnostic criteria.

Recruitment only commenced once ethical approval was received from City, University of London. Organisations such as ‘MaleVoiced’ were asked whether they could advertise my study on their website and social media. I also employed snowballing by asking close contacts whether they knew males meeting the study criteria and posted the study advert on my social media.

The study advert contained a telephone number (used only for this study) and email, so potential participants were able to contact me (see appendix B for the recruitment advert). All those interested in taking part were then sent an information sheet by email regarding the study so they could familiarise themselves with the research (see appendix C for participant information sheet).

A screening telephone call was scheduled with all potential individuals who contacted me. This took place at least 24 hours after participants received the information sheet to ensure they were familiar with the study. In this telephone call the researcher was able to discuss the research further, answer any questions, ensure individuals met the selection criteria, and arranged a convenient date for the interview.

2.5.3 Data Collection

Data were collected through semi-structured interviews (SSIs). SSIs were well suited for this research, as the search for shared meaning and active listening are skills congruent with my counselling training (Thorpe, 2013). Also, SSIs are able to answer the research question as they are appropriate for exploring beliefs and meanings (Smith, 1975). They also allowed participants the freedom to express meanings not anticipated by the researcher, thereby creating a balance between issues raised by the questions formulated by the researcher (based on the theory) and those of participants (Sullivan, Gibson & Riley, 2012).

The interview questions explored experiences of males with EDs with respect to identification of symptoms, diagnosis, treatment, and interpersonal relationships. Furthermore, the questions were designed to be open-ended, meaning they did not elicit agreement or disagreement but instead offered participants freedom to answer according to their own experiences, eliciting rich and complex data (Magnusson & Marecek, 2015).

Additionally, the interview schedule contained prompt questions to help participants elaborate their answers further whilst also allowing new data to emerge (Turner, 2010). The interview began with more general questions prior to asking more personal ones to support rapport building with participants (Willig, 2008). The interview schedule was composed of a mix of descriptive, evaluative, structural, and contrasting questions to elicit more elaborate responses (Spradley, 2016).

Examples:

- Descriptive question: *'What was/has been your experience with ED treatment and* *health professionals so far?'* This elicits the life story associated with treatment and professionals.

- Evaluative question: '*How did you feel about this treatment experience?'* This elicits feelings about an issue.

- Structural question*: 'Do you think there is any difference between EDs in women and men?'* This asks participants to organise their knowledge associated with attitudes and beliefs pertaining to ED and gender.

- Contrast question: *'How's that different from a woman with an ED?'* This requires a comparison with the previous question asked.
  - Prompt: 'How do you think others see you as a man with ED symptoms?'
  - Prompt: 'How do you think others see women with ED symptoms?'

Therefore, semi-structured interviews allowed the men to express their experiences with EDs in relation to several contexts (symptom recognition, treatment, and interpersonal relationships), generating inductive data that allowed for a better understanding of these experiences. This is consistent with the aims of this study, which was to explore this topic from the participants' point of view and generate data that were reflective of the reality of several aspects of their lives. Additionally, SSIs also elicit self-reflection and consequently increase participants' agency to intervene in their realities (Coghlan & Brydon-Miller, 2014).

At the beginning of the project, a pilot interview was conducted to assess whether the interview questions were appropriate, relevant, and generated rich data. The feedback was then used to adjust the interview questions (the interview schedule can be found in appendix D).

For the pilot interview, a male diagnosed with BED was interviewed. He met the study criteria regarding age (above 18 years of age), had a BED diagnosis, and was recruited through word of mouth. Informed consent was sought and he was provided with the recruitment flyer, participant information sheet, and debrief information sheet after the interview. The interview took place at the house of a friend common to the researcher and the participant, which provided a safe and private space in which to conduct the audio-recorded interview. This participant was included in the study proper, as he had met the study criteria and consented to take part (see appendix E for consent form).

2.5.4 Data Collection and Resources

Semi-structured interviews were audio-recorded and then later transcribed by the researcher. The transcribed interviews were stored on the researcher's computer, which is password protected.

Interviews were initially designed to take place at City, University of London, in a private room at the university campus, which would be booked for the purpose of conducting the interviews. However, due to the restrictions of COVID-19 on social distancing, all interviews took place via online video, apart from the pilot interview. The interviews were allocated a time of up to approximately 90 minutes.

Participants were offered a £20 Amazon voucher. This was not a financial incentive to take part but a fair reimbursement for their time. As stated previously, participants initially had a choice of being interviewed in person or online, enabling the study to be more inclusive of participants who would find it difficult attend the university campus in person. However, because £20 would have been offered to cover the travel expenses for those attending in person, as stated in the research materials (flyer and research information), the offer was also extended to those interviewing via online video.

2.5.5 Data analysis

Based on the first step according to Braun and Clarke's (2006) TA procedure, I first familiarised myself with the data by transcribing the audio-recorded interviews verbatim. The interviews were transcribed using a naturalised or simplified transcription that reflected participants' speech. Nonverbal cues were sometimes included if relevant, such as laughter to indicate the tone of the speech, rather than transcribing all non-verbal cues such as pauses, sighs or mis-speaking, as these are believed to represent participants' voices (Jaffe, 2007) which is appropriate to the research paradigm and aims. I also read the interview transcripts several times to search for patterns and meanings.

I then moved to the second step, which was the generation of initial codes. This was achieved using data-driven coding, which was based on the data's semantic (explicit) meaning. Next, I organised data according to meaningful segments based on identification of particular features as opposed to entire content. All coding was performed manually by naming as many different codes as possible and writing them on the document to match the codes with data extracts (collating the data; see appendix F).

Then, codes were organised into potential themes, while considering how codes and themes related to one another, leading to the creation of an initial map of themes and sub-themes for each individual interview (see appendix G).

Next, I reviewed the themes created to ensure they were meaningful and distinct. All coded extracts were then reviewed for thematic coherence, and the themes were then compared against the individual interview dataset to ensure they reflected that particular interview as a whole. Thematic maps were then updated accordingly (see appendix H).

After this process was completed for all 11 interviews, all thematic maps were compared, and themes were organised to reflect the interviews. Several thematic maps were created, and the themes and subthemes were then rearranged and reorganised several times until thematic saturation was reached (see appendix I). The themes were then linked to the collated data extracts, which created an organised account of the data, demonstrating why they were of interest and how they related to the entire set of data. Thus, the themes represented the full scope of their meaning (see appendix J).

Finally, an account of the data was written, using extracts to illustrate the argument being made in relation to the research question. These are described in full in the next chapter.

2.6 Personal Reflexivity

Reflexivity can be defined as a continuous process of self-appraising researcher's biases and their potential impact on the research process (Berger, 2015). Thus, through reflexivity, biases can be recognised and reported, leading to reliable research (Sullivan et al., 2012). In this study, it ensured the research was aligned with the critical realist paradigm, which recognises the influence of the researcher on the knowledge produced, as it is assumes reality cannot be directly assessed, but known through individual perception (Willig, 2013).

Therefore, my role as researcher was considered by reflecting on the impact I had during all stages of this research, including the choice of topic, literature review, methodological considerations, data collection, analysis, and dissemination of results. For this reason, epistemological, personal, and methodological reflexivity were considered (Finlay & Gough 2003). I will first discuss personal reflexivity regarding the topic choice and literature review. Epistemological and methodological reflexivity are addressed in detail in the discussion chapter.

My interest in researching this topic was firstly motivated by my personal interest in EDs in general and body image. I first became aware of EDs from a peer in high school who was experiencing AN' symptoms at that time. I found so many aspects of her experience puzzling, such as consuming extremely small amounts of food, baking cakes and cooking desserts often (but not eating them), being of extremely low weight with bones visible through her clothes, exercising every day, and hoarding food like sweets and chocolates in her wardrobe. However, I found it puzzling that other people did not seem to notice it and it took several months for these aspects to begin to be commented on and questioned, ultimately leading to impatient treatment and recovery.

Moreover, I was not only a witness to my school peer's experience but also related them to my own contrasting experiences, as at the time I ate larger amounts of food than I needed, found it hard to motivate myself to exercise, was considered to be above the required weight, and could never restrain myself from eating chocolates if they were inside my wardrobe!

I have always been aware of my body size and shape, as I always have been considered 'a little chubby', first by my family, and then by my own eyes. My 'chubbiness' subsequently led to body dissatisfaction, diets, weight-loss, and an interest in nutrition (mainly from a dieting and exercising non-expert magazine that was popular at the time). Moreover, achieving some weight-loss and decreasing body dissatisfaction also led to differences in the way I related to myself and others, and also of how others related to me. Therefore, I have always been conscious of how my body shape could influence so many other (apparently) unrelated experiences in my life, such as mood and socialising, and also of the strong influence of eating and exercising practices on these aspects.

Even though I do not believe these experiences impacted me in a harmful way, I am still very often aware of their role and impact on my wellbeing. For this reason, I never forgot the experience with my peer and have always wondered about the experiences of people in

relation to similar components (eating, exercise, body dissatisfaction), whose well-being and normal life functioning have been significantly impacted by them.
This led to my interest in researching EDs, but it was only through exploring the ED literature that the vast amount of research focusing on females became evident and the lack of research exploring the experiences of males. Additionally, I also realised that I had never considered the experiences of males with EDs before, which sparked my interest even further and made me wonder what experiences they might face and how they might experience them, which led to my current research topic. From the literature review, I identified a significant body of research reporting the stigma associated with EDs in general and concluded that males faced an additional stigma because of their gender.

For this reason, my first plan was to research the stigma faced by males with ED symptoms. However, upon talking to my research group and supervisor, it became evident that focusing on stigma could narrow down men’s reports to experiences associated with stigma only. This was an issue, as I was also interested in the potentially non-stigmatising experiences males may have had. For this reason, I decided to expand the focus of this research to ‘males’ experiences’ of which stigma could be a part, but was not the main focus. This then led to the present research questions and study.

It is also instructive to note that there is a parallel between my choice of topic and the historically ‘female- centric’ ED research and marginalisation of males, as my initial interest in the topic also started out as ‘female-centric’. Likewise, the process of choosing my topic choice also seems to have a parallel with gender as a system of power relations balanced in relation to each other (Messner, 1997). This is because it was only from the initial focus on female-dominant research that I became aware of male-marginalised research, as if both were keeping each other in such positions. Therefore, by tackling the marginalisation of males with ED it will hopefully be possible to increase the representation of males within ED research and thus help bring a more balanced gender representation to this area.

Accordingly, due to the focus of this research, I had to ensure I engaged in reflective practice regarding aspects such as my gender, the absence of a lived experience of ED, and my own assumptions associated with Eds in general and ED in men. Additionally, other aspects were considered, such as my foreign nationality, my body representation, and the role of power dynamics, as assuming the researcher role might imply a position of power over participants (Berger, 2015).

I considered two main positions regarding my status as a researcher. According to Oguntokun (1998), when the researcher feels they share similar aspects with the population they are investigating, such as gender and race, they might assume they share the same experiences. This in turn might lead to assumptions of meaning and result in not fully exploring participants' experiences in depth (Finlay, 2000; Cloke et al., 2000).

In my case, I believe I mostly assumed an outsider position, mostly due to differences in gender and an absence of the lived experience of ED symptoms between myself and the participants. However, assuming an outside position can bring benefits for the research, such as empowering participants because they, not the researcher, assume the position of experts on their experiences (Berger & Malkinson, 2000).

However, potentially negative aspects of this position could be the formulation of a research question that is not meaningful for participants or a lack of language sensitivity (Berger, 2005). I aimed to address these issues through the interview pilot, as previously described, to assess the relevance of questions and receive feedback from a male with a lived experience of ED. It was also crucial to constantly question, reflect, and write in a journal the feelings, assumptions and thoughts elicited by the research process, as well as addressing any biases through personal therapy and clinical supervision.

Moreover, regarding similarities, it could be argued that the participants and the researcher share similar experiences of belonging to a minority group; they as men with ED and me as an immigrant. Also, the participant in the pilot interview (Joe) and I share the same nationality, which placed me in an insider position in this regard. Such status is suggested to lead to good rapport between researcher and participants (Dwyer and Buckle, 2009), and in this case I found our shared culture useful during the interview. For instance, I was able to grasp his description of Brazilian dishes when he referred to the large amounts of food he was eating and that the meals were composed of very rich and heavy food. However, one has to be aware that the assumption of a shared understanding might lead to under-exploration of a topic, as it can lead to the researcher assuming knowledge of participants' meanings, resulting in participants not developing the topic being explored (Oguntokun, 1998). Thus, I remained conscious of not making any assumptions about Joe's experiences and remaining curious and open as to what these might be.

2.7 Ethical Considerations

To safeguard participants, the present research followed the British Psychological Society Code of Human Research Ethics (BPS, 2014) and the Health and Care Professions Council Guidance on conduct and ethics for students (HCPC, 2016). Therefore, the research was designed not to pose a risk to participants and several steps were taken to ensure this.

For instance, recruitment only commenced once ethical approval was received from City, University of London, and informed consent was sought from all participants prior to the interviews; participants also kept a signed copy of this. Prior to signing, participants were given an opportunity to clarify any doubts and ask any questions they had in relation to the study and how their confidential details would be handled by the researcher.

Interviews took place via online video. Therefore, during the debrief it was ensured that participants would have access to a device with camera and the internet and have a private place of their choosing in which to conduct the interview. Interviews were recorded using a digital voice recorder and the digital recordings were then transferred to a computer, deleted from the voice recording, and all information that could identify participants was replaced by fictitious names or redacted. All this data and information were safely stored on the researchers' personal computer, which is password protected. All information will be destroyed after 10 years as per BPS (2014) guidelines and all information about participants is being held in accordance with the General Data Protection Regulation.

Additionally, taking part in the current research enabled participants to talk about their own experiences of eating disorders, some of which were expected to be potentially unpleasant, which meant that the interview would possibly elicit negative feelings. If this was the case, the research interview was paused and the participant would be given an opportunity to express their emotions and concerns with the researcher in a safe and confidential environment. The researcher's counselling training provided them with solid skills to contain any distress exhibited by participants, but they were not to act as a therapist and should instead participants to seek further help from eating disorders organisations or their GP. However, this was not necessary, as no participants demonstrated or reported distress.

At the end of the interview, all participants received a debrief information sheet containing sources of support they can access for free, such as ED organisations. Also, participants were reminded they could withdraw from the study at any time during the research process (e.g., by terminating the interview) without needing to provide a reason or being penalised in any way. They were also reminded that they had the right to withdraw their data after the interview was completed and at any point afterwards.

Moreover, the research journal kept throughout the research process did not contain identifiable participant information, as I used anonymised data. I was the only person that had access to this journal, which was kept locked in a cabinet in my room.

Additionally, as mentioned before, most of the interviews, apart from the pilot interview, took place during the COVID-19 pandemic. However, I had already received ethical approval to conduct online video interviews prior to the pandemic. Thus, the study was deemed to be in accordance with BPS ethics best practice guidance on conducting research with human participants during COVID-19 (BPS, 2020). Additionally, during the screening call where participants were asked whether they anticipated experiencing emotional distress when talking about their experiences, the context of the pandemic was included. This meant that the pandemic did not change the research risk assessed prior to the outbreak of COVID-19.

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CHAPTER 3: ANALYSIS CHAPTER

3.1 Introduction

This chapter describes all the main themes and subthemes that emerged from analysing the eleven interviews. The themes identified answered the research questions: What are males' experiences of their EDs?' and 'How do males make sense of their experiences?' In so doing, analysis aimed to explore and understand participants' experiences around symptom recognition, help-seeking, treatment, and interpersonal relationships in regard to their ED (key areas identified by previous research) and any other experiences where their gender was reported to be relevant.

In total, eleven men with a past or current ED diagnosis were interviewed: their ages ranged from 19 to 45 years (mean age 29.5 years). Age of diagnosis ranged from 13 to 33, (mean aged 22.7 years). Of the eleven participants, three had a diagnosis of BED (Joe, Mike and Sam, although Mike identified more with AN), five had a diagnosis of AN (Dan, Jon, Max, Peter, and Ted), and three had a diagnosis of BN (Adrian, Amal, and Jake). Most had a past ED diagnosis, apart from Dan who had a current diagnosis of AN at the time of the interview and was waiting for specialised treatment, and Adrian who was diagnosed in 2020 and was in the final stages of his treatment. Demographic information for all participants is presented in Table 1.

The findings are presented by first outlining all four themes and subthemes that emerged from the data, using quotes from interviewees to illustrate them. This is followed by an interpretation and discussion of these findings using feminist theory and relevant ED literature.

Table 1. Participant demographics

	Diagnosis	**Diagnosis' year & age at the time of diagnosis**	**Age**	**Ethnicity**	**Profession**
Joe	BED	2018 (29Y)	30	Latino	Real estate agent and student
Mike	BED (Also AN symptoms, identifies more with AN)	2013/14(26/27Y)	45	White-British	Actor
Dan	AN	2020 (19Y)	19	White-British	Student
Jake	BN	2015 (25Y)	31	White-British	Mental health nurse
Amal	BN	2018 (21Y)	24	South Asian-British	No information
Sam	BED	2013 (33Y)	41	Black-British	No information
Peter	AN	2014 (25Y)	32	White-British	Stand-up comedian
Jon	AN	2009 (15Y)	27	White-British	No information
Max	AN	2007 (16Y)	29	White-British	Warehouse worker
Ted	AN	2014 (13Y)	20	White-British	Student
Adrian	BN	Feb/May 2020 (27Y)	27	Asian/ Singapore	Student

3.2 Overview of Themes

The data were organised into four main themes. The first main theme, 'EDs don't happen to people like me', refers to participants' beliefs that EDs would not happen to them. These are illustrated by the subthemes: 'EDs as female and not male disorder', which reflects participants' association of EDs with females; 'EDs are too serious', which reflects participants' beliefs that EDs are manifested through extreme symptoms; and ‘Men with ED are weak’, which reflects beliefs associated with participants’ ideals of masculinity.

The second theme: ‘EDs as paradox’ refers to men’s reports of their ED symptoms as experienced paradoxically and was divided into two subthemes: ‘Not eating but gaining’, which reflects practices associated with food restriction and weight-loss described as a gain, and ‘Eating but losing’, which reflects the practices participants associated with food consumption and weight-gain reported as a loss.

The third theme ‘Steps for change’, conveys participants’ journey from seeking treatment and getting a diagnosis to treatment and recovery experiences. It was divided into the following subthemes: ‘Help-seeking’, which conveys descriptions of seeking help; ‘Diagnosis’, which reflects the diverse ways participants’ experienced receiving an ED diagnosis; ‘Treatment and Recovery’, which covers several aspects associated with their experience of treatment and recovery; and ‘Triggers’, which conveys the triggers participants felt were associated with onset and maintenance of their ED.

The fourth theme ‘EDs are not part of men’s reality’, reflects how EDs were described by several men as not belonging to several aspects of their lives, solely due to their gender, and is composed of two subthemes: ‘Information about men with ED is not shared’, which illustrates the lack of information associated with ED in males, and ‘Men with ED don’t share’, which reflects several aspects associated with sharing, including challenges, facilitators, and the benefits of doing so. An overview of all themes and subthemes is presented in Table 2.

Table 2. Overview of themes and subthemes

Theme 1. EDs DON'T HAPPEN TO PEOPLE LIKE ME

1.1 EDs as female and not male disorder

1.2 EDs are too serious

1.3 Men with EDs are weak

Theme 2. EDs AS PARADOX

2.1 Not eating but gaining

  2.1.1 Weight-loss as sport

  2.1.2 EDs as part of identity

2.2 Eating but losing

  2.2.1 Eating as an addiction

Theme 3. STEPS FOR CHANGE

3.1 Help-seeking

3.2 Diagnosis

3.3 Treatment and recovery

3.4 Triggers for EDs

Theme 4. EDs ARE NOT A PART OF MEN'S REALITY

4.1 Information about men with EDs is not shared
4.2 Men with EDs don't share

3.3 Analysis

3.3.1 Theme 1. EDs don't happen to people like me

This theme reflects participants' reports that EDs would not happen to them due to beliefs associated with EDs in general and ideal gender norms. It is composed of the subthemes 'EDs as a female and not a male disorder', 'Men with ED are weak', and 'EDs are too serious.'

3.3.1.1 EDs as a female and not a male disorder

The first subtheme 'EDs as a female and not a male disorder' reflects men's initial disassociation of their experiences from ED symptoms due to beliefs of EDs as a female and not a male disorder, and some of the consequences and reasons they associated with this. Most believed EDs occurred mainly in females instead, and were also self-inflicted, as reported by Mike:

> *"(…) I didn't think men could get eating disorders, eating disorders for me were for, genuinely for teenage girls, and it was a cry for help. I was quite negative towards eating disorders, because my attitude was like quite a lot of people's, just have a pie [laughs] (…) Because that's the background I come from (…)" (Lines 421- 424; 428).*

Moreover, such beliefs led some participants to experience the ED diagnosis as a shock, as noted by Ted:

> *"I think a lady from there (CAMHS) came in and basically said like 'yeah, you've got an eating disorder' and to me and my parents, I think my parents were there, and we were pretty shocked like, I as I said, I didn't know what it was, I didn't really know anything about that other than, obviously I heard the words um and I think I just assumed that only happens to girls and um like and there was, I think I obviously maybe thought before, it was like a conscious decision by them, they wanted to have one you know what I mean (…)" (Lines 410-419)*

For others, such beliefs made them question whether they were normal. Adrian, for example, explained that he did not know any other men with an ED:

> *"(…) because at first when I found that about that [had BN] you know I was kind of like questioning myself if I'm normal or 'why is it happening to me, a guy?' as my other male colleagues and friends don't have the same thing (…)" (Lines 1079-1083)*

However, some participants, like Peter, reported that they were aware EDs were not exclusively a female disorder:

> *"(…) gender has never been one of my first explanations (…) it was never something that was strong in the mind that men don't get eating disorders, that was never something that was in front of the mind, perhaps it might have been subconsciously, but no." (Lines 251; 253-256)*

Nevertheless, Peter still associated the consequences of AN with females when comparing these to his ideals of masculinity:

> *"I quite liked how the anorexia helped me be less masculine, and helped me be more feminine (…) I suppose I never really liked being a manly man (…) what I mean is sort of um in the sense of sort of, I mean look at any actor advert you know, Gillet razors, Lynx aftershave you know, it's kind like 'men love football and beer." (Lines 973-974; 977; 995-998)*

Peter also associated EDs with cultural factors, such as greater emphasis on weight concerns and food restriction among females than males, while food consumption was implicitly reported to be more associated with males and not taken seriously as a disorder:

> *“I suppose like the diet culture and weight and stuff is weighted more towards uh sort of women, I think there is a sort of disparity generally within the eating disorders like binge eating disorders are absolutely not taken seriously (…)” (Lines 1008-1112)*

For Sam, higher occurrence of EDs in females was described as being due to biological and psychological gender differences:

> *“ I still think that it slightly affects, there’s something in the bodies of women, and maybe the psyche uh that affects women more than men (…) I think there’s something maybe biological and uh neurological um that in terms of the effects of what food does to women, what the body demands, what the body wants in terms of I don’t know, if it’s something to do with fertility, uh all of these other things, obviously like uh menstruation, periods, and all of these elements that occur within uh the female form that I think there’s this over-reliance on food and how that impacts the females (…)” (Lines 725-731; 736-743)*

Moreover, Jake believed EDs occur more in gay men than straight men:

> *“(…) within the gay community there’s quite a lot of eating disorders and extreme behaviour, so it’s not unheard of, I think the prevalence is higher when you look at LGBT communities compared to just men.” (Lines 865-868)*

Furthermore, some participants believed that the higher association of ED with females results in females receiving faster treatment, as stated by Jon:

> *“(…) like all the females that were in hospital like they had like a, not to compare, but they had a fairly breeze um in terms of getting to the stage of help, um like it was believed, like pretty much, say if a girl loses loads of weight and is really skinny the*

> *doctor will think 'oh it's probably anorexia, it's probably an eating disorder because she wants to look like some model or something', but for men it's just like food fad (…)" (Lines 1229-1236)*

On the other hand, Dan questioned whether the wider general knowledge that EDs affect mostly females could hinder females' help-seeking as a result of perceiving their symptoms as normal:

> *"I don't know, if I was a girl hum, I don't know, 'would I've sought help?' because I would have seen that some people just do it and they just get on with it you know, you know [my therapist] said to me that a lot of the girls she speaks to hum you know, maybe haven't spoken you know...have kept this kind of to themselves for years (…)" (Lines 1019-1023)*

Overall, these reports reflected participants' beliefs that EDs would not happen to them because of their male gender, resulting in some feeling shocked when receiving an ED diagnosis or questioning whether it was normal to be affected by an ED. Participants associated EDs more with gay men than straight men and more with females than males, which they attributed to social, cultural, psychological, and biological ideals associated with male and female genders. Additionally, some participants believed ED in females is recognised more readily by professionals, while others questioned whether the normalisation of ED in females could act as a barrier to seeking help.

3.3.1.2 EDs are too serious

Some participants reported that in addition to believing that EDs mainly occurred in females, they also manifested in extreme symptoms, which impaired their recognition of their own symptoms, as reported by Dan:

> *"(…) you know I've heard of anorexia and when you think of anorexia you think of a really skinny girl you know, that…that's what comes to mind, hum and then even like in July time, June, July time you know, I didn't think I had an eating disorder, I just thought I was just a bit restive, but now kind of now…yeah now I can see anorexia is something completely different you know, you don't have to be stick-thin (…)" (Lines 154-160)*

Jon also associated AN with extreme symptoms, which acted as a barrier for him to recognise his experience as ED's symptoms:

> *"I knew about them [EDs], um from school and stuff um, but to me I think, I don't know why, but because of the 'x' in anorexia it just sort of seems a bit like scary at that time, like it just seems a bit like serious um, because it's quite a cutting word like 'anorexia', like is not really a nice word, um so when they told me, again I was like in disbelief, I was like 'nah, no', or something so serious for someone so lazy, like the symptoms of exercising wasn't there um so I didn't believe it" (Lines 1054-1061)*

Similarly, Peter did not think his symptoms were extreme enough to be a symptom of ED and also did not match his experience of enjoyment:

> *" (…) [ED] was very much a crazy thing that was very melodramatic and something that happened to celebrities and it was something I didn't really sort of think about relating to me (…) it was also something that I always associated with like crying and despair and bla, bla, bla, whereas actually what I was doing, I got a buzz and kick out of it, so obviously ain't something negative, because I'm enjoying this, I suppose was also the thing that you know I wasn't, yeah so you know I didn't look thin, I wasn't moments away from death, and I wasn't mad, those things that sort of media portrayed and it was a very binary thinking sort of, hearing voices or you know sort of doing things*

> *that are very out of character, whereas I was just an average kid like rumbling around really." (Lines 21-24; 147-158)*

Thus, associating EDs with extreme symptoms affected some participants' recognition of symptoms as they did not match their experiences, as demonstrated in these examples of feeling restless, lack of exercise, and enjoyment.

3.3.1.3 Men with ED are weak

Several participants associated their EDs with weakness and blamed themselves for the onset of the disorder due to beliefs that men are supposed to be strong, as reported by Amal:

> *"I think it's also probably more acceptable for women to have an eating disorder, it's more accepted, I told you, you know for a man or if you are a male yeah, you are supposed to be stronger, you are supposed to be healthy etcetera and I think that shows a sign of weakness you know, which a lot males or men don't really want to see maybe, maybe they don't, maybe they can't stand it you know." (Lines 1029-1039)*

Also, Sam reported initially associating EDs with weakness and self-infliction, which went against his cultural ideals of masculinity linked with strength and discipline:

> *"(…) I had a sort of masculine prejudice against it [EDs]. Well, you know so that's sort of masculine ego of uh not wanting to show signs of weakness, not wanting to acknowledge weakness, so incapacities, um feeling like not wanting to admit uh lack of controls, so that's, that's my culture, that's kind of where I come from (…)" (Lines 307; 310-314).*

Therefore, for some participants, EDs were associated with weakness, which contravened their masculine ideals of strength and discipline. Furthermore, the theme 'EDs don't happen to people like me' demonstrated that most participants did not believe EDs could affect them as they associated them with females, self-infliction, extreme symptoms, and weakness, none of which matched their experience of the disorder.

3.3.2 Theme 2. EDs as Paradox

This theme reflects participants' reports of experiencing ED symptoms as a paradox. For example, several participants described experiencing loss as a gain, while gain was described as a loss. Thus, the first sub-theme, 'Not eating but gaining', reflects how some participants initially perceived behaviours, cognitions, and feelings associated with their EDs as a gain and not a disorder. This was further divided into 'Weight-loss as sport', which describes weight-loss being experienced as a sporting practice for some participants, and 'ED as identify', which describes ED symptoms being experienced as part of participants' identity, resulting in difficulty acknowledging it was a disorder to be treated.

The second subtheme, 'Eating but losing', reflects practices participants associated with food consumption and weight-gain that resulted in negative feelings, cognitions, and behaviours, along with experiences of loss of control that were akin to an addiction. Moreover, for several participants, realisation of a lack of control led to a recognition that something was wrong, leading to help-seeking.

3.3.2.1 Not eating but gaining

This subtheme reflects EDs being experienced as a gain by some participants, as certain practices were described in terms of their benefits or in terms of being part of participants' self.

For instance, ‘Weight-loss as sport’ reflects participants’ experiences of food-restriction and weight-loss as a competition which involved achieving targets that led to a sense of achievement and enjoyment when met. Conversely, ‘EDs as identity’ reflects participants’ reports of experiencing EDs as a part of who they were and/or behavioural repertoires.

3.3.2.1.1 Weight-loss as sport

Eating-restriction was described by several participants as a sporting practice, as they reported experiencing food-restriction and weight-loss in terms of a competition, which included goals, perseverance, and feelings of joy and achievement. Purging behaviours were also described in terms of meeting weight-loss targets and associated with achievement.

Some participants reported weight-loss as a target they aimed towards. Mike, for example, described setting unachievable weight-loss targets and trying to accomplish them by restricting food intake as a form of competition:

> *“(…) [losing weight] became competitive, my mind-set at that the point was, I can lose more weight so instead of setting myself a target weight of say 8 stone, I’d always say, I can lose another half stone… when you set yourself a target of ‘x’ amounts of, I either want to lose five stone or I want to be 12 stone, that’s an achievable target, whereas when you are unwell, you set yourself an unachievable target, so you say I can always lose another half stone (…) and it’s a weird mind-set, it doesn't make any sense, but that’s the thing with eating disorders, mental health issues are highly difficult, but eating disorders are so incredible complex, they defy logic a lot of the time.” (Lines 236-252)*

Similarly, other participants, Amal (BN), Peter (AN) and Jon (AN) described having weight-loss as their target, with Jon reporting AN to function as a certain way to meet his target:

> *Jon: "(…) anorexia, that was like the sure way to lose weight, it was almost like a target um like you are definitely going to lose weight" (Lines 1094-1095)*

Moreover, some participants described feeling a sense of achievement resulting from ED behaviours, as described by Mike when he purged through being sick and diarrhoea:

> *"(…) but erm I'd be violently sick the morning after this, quite an aversive reaction to it, it doesn't stop me unfortunately, but I felt I had bypassed the food I was eating, it was a bit of sense of achievement with it, and the more uncomfortable (…) the ring sting, the side effects of having spicy foods on you (…) the more severe the ring sting, the more I enjoyed it. I felt like a sense of achievement, like I really achieved something." (Lines 1031-1035; 1036-1042)*

While Peter (AN) described the possibility of dying from AN as the ultimate accomplishment to his commitment to weight-loss:

> *"(…) I suppose that I saw being taken by the anorexia as the ultimate graduation, the ultimate accolade that nobody could ever doubt my commitment to the cause I suppose."* (Lines 301-304).

Also, some participants diagnosed with AN, described losing weight and being thin as enjoyable, as exemplified by Peter and Ted:

> *Peter: "I enjoyed the buzz of the restriction, I enjoyed when I was on top of it, I enjoyed when I lost weight, so it didn't really feel like a problem (…)" (Lines 64-66)*

> *Ted: "I almost weirdly like I enjoyed being like that really skinny person, I also know a lot of people with eating disorders can be like secretive and like they purposively wear*

> *baggy clothes to like hide the fact they are skinny and stuff like that, whereas I'd almost do the opposite, I'd purposively wear like really skinny jeans, because I almost enjoyed the fact that I was really skinny, which is obviously, maybe I didn't add that up but yeah (…)" (Lines 1474-1481)*

These reports illustrate males' experiences of symptoms such as food restriction, weight-loss, purging, and having a slim body as enjoyable and resulting in a sense of achievement, thereby highlighting the perceived benefits of symptoms in their lives.

3.3.2.1.2 ED as part of identity

Moreover, the subtheme 'ED as Identity' reveals how some men experienced their ED as part of themselves, as they described aspects of their ED as being part of who they were and a way of coping. Ted for example, perceived his low body weight as a component of his identity:

> *"(…) like I purposively like would show off, not in a weird, I wouldn't want to show off I had an eating disorder, but show off I was skinny, I always enjoyed that side of my personality." (Lines 1478-1485)*

While others reported that their ED behaviours were a way of coping that was viewed as belonging to be part of themselves, as exemplified by Jake:

> *"(…) or really had probably enough insight [about BN] to be like 'oh yeah, that's me, that's what I do', it was just a way of coping hum until I was 21(…)" (Lines 61-63)*

While Sam and Peter described their EDs as associated with a pig that is part themselves:

> *Sam: "(…) I mean I put it crudely, I always feel like that little piggy is still in there, inside with me, like there's that element there, uh I feel it and I acknowledge it (…)" (Lines 646-649)*

> *Peter: "(…) I'd always been this fat little 'oink' (…)" (Lines 444-445)*

Furthermore, perceiving ED as part of themselves was a barrier to symptom recognition for some participants, as reported by Jon:

> *"(…) it was just the way I was, I think because I was so young and I grew up with a food issue all of my life, I just assumed that my behaviour was normal that everyone was like coming for me, like no one would leave me alone (…)" (Lines 86-89)*

In this subtheme, participants reported experiencing symptoms as part of their identity, way of coping, and also as an element of themselves they identified with a pig. Moreover, for some, identifying symptoms as part of who they were became a barrier to identifying their experiences as a symptom to be treated.

3.3.2.2 Eating but losing

On the other hand, the subtheme 'eating but losing' reflects the paradox of how participants experienced eating and the physical gain of weight as a loss. Eating and binge-eating were described as an addiction that despite initially leading to pleasant feelings, ultimately led to a lack of control and negative psychological and physical consequences.

3.3.2.2.1 ED as addiction

The following descriptions depict several aspects that define an addiction: lack of control; harmful consequences to physical and psychological wellbeing and also to social life; feelings of short-lived enjoyment followed by feelings of guilt and despair due to withdrawal or 'come down' symptoms; cravings and powerful urges to satisfy them.

Joe, for example, compared his binge-eating with the inability to stop smoking cigarettes:

> *"... it's like starting smoking, you start like with one cigarette and then when you see you smoke the whole pack. Eating is the same, you start eating something and then when you see, you don't stop, you don't stop..." (Lines 706-709)*

Several participants described low mood as a result of consuming food. Sam for example, also directly compared his binge-eating with a drug that resulted in positive feelings followed by low mood:

> *"I mean I used to compare it [binge-eating] to someone uh it felt like a drug, I mean, I don't have the experience of drug use, recreational use, but I kind of drew a comparable with that from what I know, uh the little I know about it in terms of needing that hit and then that uh that high and then it sometimes, then the guilt and coming down on a yeah the sort of a rollercoaster type associations with it was really weird (…)" (Lines 969-975)*

Moreover, some participants described a powerful urge to purge followed by eating; in Ted's case it was an urge to exercise:

> *"I just eat the calories and I think in your head I can just almost sense it, almost feel it in my body like, feel it in my body, like I hate it, I still or other times I hate the feeling of being full, um I yeah, I just sort of obsessively wanted to exercise (…)" (Lines 647-651)*

While for others it was an irresistible urge to vomit, which impaired their ability to perform their daily tasks, as exemplified by Adrian:

> *"The only way I can think of it [purging] is sort of a like an urge to go to the bathroom after meals, so it's like a necessity that I realised I have to do you know, if I don't do it I was unable to continue the rest of my activities for the day so as a student that would mean I would not be able to study properly or do anything, or meet people because at the back of my head I'd keep thinking 'oh go to the bathroom' you know 'go to the bathroom, you need to vomit out whatever you had for dinner' yeah, so it became a bit like of a process that you know if I don't fulfil every day, it just didn't feel right yeah." (Lines 105-115)*

Furthermore, analogous to an addiction, several participants described some behaviours associated with their ED as unsustainable. Ted for example reported crashing and burning down as a result of eating less:

> *"(…) I was just eating like eating less and then like my times were getting quicker and better and so I guess was only young and in my head like it was like 'oh I'm eating less and I'm running better and like keep doing this and like I keep getting better, better, better', and obviously that can work for like maybe a little bit of time, but then obviously I completely crashed and burned out (…)" (Lines 85-92)*

Similarly, some participants (all sharing AN diagnosis), reported low energy levels and mood as result from their ED. Dan for example, reported his AN resulted in extreme fatigue that let him unable to leave his bed:

> *"I was kind of ticking all the boxes you know, erm about not just the behavioural sides, the eating and exercise sides, but also the physical kind of side you know, fatigue,*

> *tiredness, um just feeling generally ill um and stuff, so yeah it wasn't just the mental struggle you know, I, sometimes I was getting so bad to the point that you know I couldn't leave my bed physically, because I was so knackered and um exhausted…" (Lines 289-296)*

While Max reported having his future life's prospects negatively affected:

> *"(…) sort of personality-wise, like I feel like having got so skinny and reduced my weight and stuff, I feel like it had some effect on my uh enthusiasm and energy for life after, so it's like I'm sixteen right and I should be pursuing my interests and stuff and trying to get started in life, but I felt like I had less energy to do stuff and less um less drive." (Lines 1311-1316)*

Moreover, Ted also reported changes in his personality which affected his social life:

> *"I completely changed my character as well like I guess, I'm pretty an outgoing person I'd say and I'm quite like social and then like happy to you know I enjoy like pretty much socialising all the time and I completely became like an introvert in a space of probably like six months, like I wouldn't want to go to school, I wouldn't want to see people and as I said I was just sad all the time, I was like really cold all the time, um and things like that and you know I was sort of cried fairly regularly and stuff like that, it wasn't just like me at all as well and obviously I lost a lot of weight" (Lines 275-285)*

On a parallel note, Joe reported that it was his dissatisfaction with his weight-excess that led him to avoid social interactions:

> *"... I felt so uncomfortable about myself, I didn't want to talk to anybody like, I just wanted to be alone, I didn't want to be part of anything or nothing, I didn't want to go*

> *to friends' houses. I didn't want to go on holidays with friends, I just, I just...until I sorted this problem..." (Lines 668-72)*

Additionally, Dan also reported believing that he developed a lifelong autoimmune disorder as a consequence of his AN:

> *"I tested positive for Coeliac disease hum which doesn't run in my family, I've never struggled with gluten, but obviously I think the massive restriction of bread and past and stuff that is considered to be 'carby' and calorie-food, and you know the restriction from that from my diet has caused my body to start erm you know rejecting it and not liking it, because I've, you know I've done damage to myself you know" (Lines 164-170)*

Some participants reported a difficulty to identify EDs' associated behaviours and consequences as problematic, as exemplified by Peter when he compares EDs with alcohol use:

> *"(…) it's difficult to know when a social drinker becomes an alcoholic and I think it's exactly the same with someone losing weight and that being a full-blown eating disorder" (Lines 389-392)*

Similarly, some behaviours associated with EDs, such as exercising and consuming less sugar could be more associated with beliefs that they are healthy which in turn could also function to mask ED symptoms, as stated by Dan:

> *"(…) but yeah so I guess in lockdown before I moved to London it wasn't really obvious that I had an eating disorder, it was just obvious that I was eating healthily and exercising lots and being very aware of what I was eating…" (Lines 493-497)*

Moreover, lack of control which is one of the main components of an addiction, was reported by several participants regarding their EDs. Dan for example, described lack of control over thoughts regarding food and exercise:

> *"(…) the only way I can describe this thing is that it's literally um on my mind um every day, every minute of every day you know, that's the extent of the food and the exercise I kind of say they kind of equally balance." (Lines 1134-1137)*

While others reported lack of control over stop eating as exemplified by Joe:

> *"When I realised it [that was binge-eating], was already too late, like I wouldn't, I wasn't able to control myself..." (Lines 266-267)*

Also, some described lack of control over reducing calories from diet as Ted:

> *"(…) and I guess it went from just reducing like sugary stuff or like stuff that maybe weren't necessary to then start reducing like calories and I guess then when it started like getting out of control." (Lines167-170)*

However, awareness of lacking control led to most participants realising they had a problem, as poignantly stated by Sam:

> *"(…) I couldn't stop thinking about uh going and buying like sweets, like Haribo and bad stuff, I just could not, I was in bed for hours until four, five in the morning, I couldn't stop thinking about it and I had to go out into the street into (name omitted) to the shop, to an over twenty-four hours off-license and go and buy this food, came home, ate it and just realised, this uh, this is wrong, this is not, this, this is sending me down the*

> *wrong path and I went to go and see my doctor after that, so yeah that particular episode was a catalyst for it really, um yeah." (Lines 65-74)*

Also, Sam realised he needed from others to address his symptoms, and subsequent help-seeking which will be explored in the next theme:

> *"(…) just important for me, it was about me realising that I had a problem and the problem wasn't something I could fix on my own this time (…)" (Lines 231-233)*

For all these reasons, this theme depicted participants' experiences of ED symptoms as a paradox, as it entailed experiences of physical weight-loss and its associated behaviours, cognitions, and feelings as a gain, described in terms of sport and identity. At the same time, this theme also entailed experiences of physical weight-gain and its associated behaviours, cognitions, and feelings as a loss, described in terms of addiction, which negatively impacted physical, mental, and social aspects. However, some behaviours associated with their ED, such as exercising and eating less sugar, masked their symptoms due to their apparent healthy nature. However, feeling out of control was the aspect mentioned most frequently by participants as alerting them to their symptoms, which leads to the next theme.

3.3.3 Theme 3. Steps for Change

The theme 'Steps for Change' depicts participants' journey through help-seeking, treatment and recovery, and several other related aspects, such as the triggers they associated with the onset and maintenance of their EDs and aspects that were helpful and unhelpful to them in navigating their journey. This theme was divided into the following subthemes: 'Help-seeking', 'Diagnosis', 'Treatment and Recovery', and Triggers'. 'Help-seeking' conveys descriptions of help-seeking, which includes reports of agency, while 'Diagnosis' depicts participants' making sense of their symptoms and their diagnoses with primary healthcare providers. ‘Treatment and Recovery’ covers their experience of treatment and recovery and the helpful and unhelpful aspects associated with these, while ‘Triggers’ conveys the effect of family and cultural background on food practices growing up.

3.3.3.1 Help-seeking

Most participants reported self-agency with respect to help-seeking, as they sought their GP’s help once they identified their experience as symptoms, as exemplified by Sam and Jake:

> *Sam: “(…) well I suspected, I realised I had a problem, came to him with the problem, he acknowledged the potential of that problem and referred me to a specialist and it went from there.” (Lines 15-19)*

> *Jake: “I think probably self-diagnosed, went to my GP and said ‘I’m pretty sure I’ve got bulimia, this is what is going on’…” (Lines 792-793)*

Also, knowledge about the healthcare system proved helpful for help-seeking agency regarding treatment choices as reported by Jake:

> *“I think having inside knowledge of the NHS and stuff really helped me, hum because I knew I could refer to an IAPT anywhere, it doesn’t matter and I can make that choice, hum so I referred again to the same IAPT.” (Lines 101-105)*

Furthermore, for Ted, Max and Jon, all underage at the time, help-seeking was initiated by their parents. For Ted for example, heart pain from excessive exercising led his father to take charge by taking him to the local hospital’s emergency department:

> *"I was running probably too much and I was doing probably excessive exercising still, and I think I run like maybe the day before, or maybe even that day and my heart was actually like hurting and my dad was being like you know 'this is enough, I'm taking you now'…" (Lines 266-275)*

While Max reported his parents took charge over help-seeking as he did believe he had a problem:

> *"(…) initially I was quite resistant to the idea there was an issue or that I was anorexic or anything like that (…) Um so I disagreed with the uh the doctor and my parents, because in a sense my parents were the ones that took me there, as opposed to me wanting me to go there or anything like that (…) I think they wanted me to have more than one meal a day, but I think they couldn't hum like force me to do stuff, so they decided to go sort nuclear and then take me to a clinic." (Lines 32-40; 231-234)*

These reports of help-seeking mostly involved descriptions of agency. Self-agency over help-seeking was associated with symptom identification and knowledge of the healthcare system, while lack of self-agency was associated with being under-age at the time of help-seeking and a lack of symptom recognition by participants – but not by their parents – which in turn affected participants' diverse experiences of diagnoses, as discussed in the following section.

3.3.3.2 Diagnosis

The experience of being diagnosed with an ED was reported in several ways by participants; some experienced it as a shock, while others already expected they had an ED when they sought help for the first time. However, for all participants, the diagnosis helped them make sense of behaviours, feelings, and cognitions associated with their ED. Additionally, reports regarding their experiences with diagnosing professionals varied from being described as positive for some and extremely negative for others, with most participants attributing to healthcare professionals a lack of ED knowledge and time as reasons for their lack of appropriate treatment.

Several participants described receiving/getting a diagnosis as helpful in making sense of their symptoms. Mike, for example, referred to having an awareness that his behaviours as problematic, but could not conceptualise them as symptoms of an ED:

> *"(…) I knew these behaviours weren't normal, but I could not make sense of it, and then when I got the diagnosis of anorexia, I went 'oh okay, yeah that makes sense'…" (Lines 348-350)*

For Amal, the diagnosis was received both as a shock, because he was not aware he had an ED, but also as comforting because it was an identifiable disorder:

> *"So he [GP] told me this and then I, I was in shock right, because I think it's just someone putting a label on it, so I think it kind of it's good that this is a common thing, not a common thing, but the fact that it's not unknown discovery it's quite comforting, because if he had said to me 'I never heard of this, I have no idea what this could be', I think you panic in your mind right, you are like 'oh my goodness, what could have happened'." (Lines 396-404)*

Ted experienced his diagnosis in a similar way to Amal, as he felt relieved due to having his symptoms validated outside of his family, however he also felt shocked and embarrassed:

> *"Oh yes, so I was just saying like obviously maybe as well a relief that maybe people actually is taking notice that sounds weird, but like yes that people were actually like realising something was wrong, whereas before it was just my, my parents and me*

> *and like I didn't know what to do about it and like everything was rubbish, but then like some people, taking me there as much as it was shocking and embarrassing, you are like 'ah at least sort of there are people that actually finally listening to what I'm trying to say', yeah." (Lines 548-557).*

However, participants described several barriers to being diagnosed. Jon for example, described the GP not listening to his mother's repeated complaints about his health in terms of a fight and resulting in him not getting appropriate help sooner:

> *"I didn't realise how much my mum was fighting the doctors until I got my GP records (…) I think it was over thirty times before they [GP] even considered CAMHS, like it was mental like [laughs]… I could have gone sooner if they just listened (…)" (Lines 232-233; 235-237; 241)*

Jon added that his visits to Pro-Ana websites were used by his mother as ammunition in her fight to get him diagnosed and treated:

> *"(…) she [mother] went through she went through mine uh my PC, so she's found all of the pro-ana um sort of skinny sites and stuff um and I think that's when it sort of got a bit more serious for her, um not for me, but for her it's um it gave her some more ammo to fire back at the doctors to get me treated…" (Lines 214-218)*

Another barrier to the diagnosis reported by some participants was lack of an evident change in body type as described by Ted, despite his low weight being described as extreme:

> *"(…) because I said I've always been quite a skinny guy, like I probably lost like a good ten, twelve kilos, I was probably like fourteen when it was like twenty-nine, twenty eight, um which is obviously a lot, so twenty-five per cent of my body weight, but like um*

> *yeah, I didn't really how it was actually like, almost like bit horrible to look back at, um so that's why I was surprised looking back now as well, the GP didn't really see much wrong, so we went there, I think he did a couple of blood test as well and they were like, they were low, but he was sort of just like 'oh, just come back to me in a couple of months, try and write some food and stuff down and stuff' when I guess like my body was almost sort of shutting down, but yeah." (Lines 225-237)*

Also, no evident change in eating-behaviour, was reported to be another barrier by Jon, that was considered to have a 'food-fad', despite his constant weight-loss:

> *" (…) the doctors weren't listening, they weren't believing um, they just thought it was a food fad, so I was just a skinny teenager until was, I remember parts of the meetings and the doctors just didn't really care, um they just, because I had this food fad all of my life they just assumed that I was being fussy, um but I was like a skinny boy and was not until my mum sort of really got angry and say 'no, he's literally losing like a kilo every like two days' [laughs] like 'this is not right." (Lines 202-209)*

Moreover, some participants' symptoms were not recognised by their GPs until they became severe and they needed urgent help as described by Jon and Ted:

> *Jon: "… um it took quite a while for them to take it seriously, uh before that stage where I did actually need like inpatient help, it was when I went to the uh the hospital (…)" (Lines 38-41)*

> *Ted: "…they [A&E doctors] were saying like 'you know if you didn't come in the next couple of weeks, sort of anything could've really happened'…" (Lines 295-297)*

However, other participants reported a positive experience with their GP when seeking for help. Jake for example reported having a good relationship with their GP when they sought for help to address ED for the first time, such as Jake:

> *“I approached my GP, huh who I had a really good relationship with and asked to be referred to IAPT, hum which was done 65-66 (…) she’s known me since I was a baby, hum I had a really good relationship with her, hm and I have no issue going in saying this is what I’m struggling with, can you help me?” (Lines 456-458)*

Still, Jake also reported feeling dismissed when he consulted an unfamiliar GP when his symptoms returned:

> *“I’ve seen another GPs and they have been quite dismissive of it or then just said ‘oh have some Citalopram hum and come back in six weeks’ (…) and the doctor was more quite dismissive of it and more wanting to say ‘oh we can just treat you with depression, it’s much quicker’ hum...” (Lines 550-552; 565-567)*

Jake also reported feeling vulnerable at the time as a reason not to challenge the GP unhelpfulness, despite his professional background as an ED mental health nurse and his previous experience with diagnosis and treatment:

> *“(…) I just agreed with her, because I think when you go feeling so vulnerable and scared anyway, and I would feel like a failure because I had treatment a few years ago, hum for her to then just say ‘oh well have some antidepressants’ was not very nice.” (Lines 585-588)*

Moreover, Jon and Ted also considered whether their GP did not identify their symptoms because of their male gender:

> *Jon: "… but yes that's always been a struggle like trying to get a diagnosis, trying, they just really didn't believe me, I don't know why, because I was a male or because of anything, I don't know, uh you know I was in the doctor's hands, but yeah." (Lines 42-46)*

> *Ted: "…the GP, he might have recognised it quicker, but obviously he saw me as a male and was sort, and maybe he just dismissed it, the fact that like yeah, it was something else or just like that I was a skinny guy sort of thing…" (Lines 1380-1391)*

While for most participants that went through these unhelpful experiences, reported lack of lack of ED knowledge as a reason for their health-carers' attitudes, as exemplified by Mike:

> *"...yeah, I just think he didn't had enough knowledge about eating disorders, he you know, he did it very well, he [GP] did it very sensitively (…) He had the right stick but the wrong end." (Lines 1317-1322)*

Jake also mentioned lack of time as a reason for their unhelpfulness:

> *"(…) you cannot expect a GP to make a significant difference in 10 minutes of a mental health problem, because it's not as easily fixed as a physical health problem." (Lines 1238-1245)*

For these reasons, Peter reported that resources such as an information sheet about EDs and treatment, could have been helpful to his experience at the time of the diagnosis:

> *" I think if I had known about Beat, they didn't release it back then, but just released a resource on Beat's website where basically it's a sheet that the print off and in your own time you fill it out and then you go to the doctor you can just like give them this*

> *filled-out printed-off sheet hat's sort of says everything and at the bottom it sort of says to the GP 'these are the resources, this is the golden standard for how you refer this person, etcetera', I think that would had been incredibly useful …" (Lines 1104-1112)*

This subtheme demonstrated that the experiences of diagnosis helped some participants to make sense of their symptoms, while for others it was experienced as a shock and embarrassment. Moreover, for some the diagnostic process was described as a struggle and involved several visits to the doctor. In addition, no obvious or sudden changes in body-type or behaviours were listed as barriers for symptom identification (despite the extreme low weight), which led to delayed treatment and worsening of symptoms. Lack of time and ED knowledge were reported as reasons for lack of symptom identification or the lack of appropriate treatment offered by professionals.

3.3.3.3 Treatment and recovery

All participants reported several helpful and unhelpful aspects of their experience of treatment, such as the individual characteristics and modality of therapists, treatment setting, treatment strategies and benefits, treatment difficulties and preferences, self-help strategies, the role of power in treatment, and self-agency in recovery.

Therapists' characteristics

Participants described several individual characteristics of their therapists and caregivers that they found helpful and unhelpful during treatment. Several described their female therapists as warmer than their male therapists. For example, Jake perceived the male therapist as more focused on behaviour change and the female therapist as focused on exploring emotional content:

> *"(…) the female [therapist] was much more warm, hum I think I bonded with her much better, hum and I supposed felt more able to talk about actually how I'm really feeling and what's going on behind it. I think the relationship with the guy that I saw was, it was much more kinda like 'let's do this, let's change behaviour, what can we do to change it', hum so there was positives and negatives to both sides." (Lines 601-610)*

Additionally, Jake found helpful to have a more humanistic approach rather than the behavioural approach when sought help for the first time due to his supposed vulnerability at the time:

> *"(…) they [both therapists] were both equally helpful in their own right, but if it been the other way and I'd seen the guy first and it had been very kind of behavioural focused and don't whether I'd have taken that, because I think it was such a breaking point when I was 21, it was I didn't have the energy to be able to even think about changing behaviours." (Lines 630-637)*

Still, his preference could have been influenced by the psychological modality practiced by the therapist rather than the therapists' gender. However, a similar experience was reported by Ted, as he experienced the male therapist as abrasive and not a good listener, which in turn affected his treatment's experience:

> *"(…) the one that I didn't really get on it was actually male, the family therapy person; I think I just don't know what it was, I think it was I don't know maybe that could be quite stereotypical, but like he was quite like you know abrasive and like 'this is what is happening', I think this is what I remember the most, he'd be like, he'd be quite like almost too sure and be like you know 'this is what's happening and this is what needs to change', I think we were, my family was sort of there like 'never, that is not happening' and he wouldn't really listen (…)"* (Lines 917-932)

Ted also reported finding the balance between strict and lenient and knowledge as helpful therapists' characteristics during treatment:

> *"(…) they (FEDS) know when, how to be strict but also to have like a bit of fun and like things like that and I guess just the way they presented things and the way they talked to me and stuff like, it just felt they were knowledgeable and they were like, they understood me a lot more, do you know what I mean, they understood what was going on in my head a lot more than the others yeah." (Lines 890-896)*

While Jon reported that someone described as 'too caring' was unhelpful during his treatment:

> *"I had one she was [laughs], she was too much like my mum, so I didn't want to talk to her at all, she was just too mother like um to sort of I guess caring, um so I changed my therapist to a more sort of um sort of someone different basically" (Lines 289-298)*

And he described preference for direct therapists:

> *"(…) they [therapists] were fun, they were real, they said how it was um and to this day I very much 'vibed' to people like that, sort of direct people like they could happily say to me like 'you look terrible today' like and I would like respect that, I would like 'okay, fair enough, I am' um they're at the people that I definitely 'vibed' the most um so just sort of more realistic." (Lines 476-481)*

Despite the vast majority not reporting therapist's gender as relevant, Adrian for example, initially expected that it would be easier to talk to a male therapist rather than a female one, but during treatment gender became irrelevant to his treatment's experience:

> *"(…) initially when I started the treatment first, I thought that you know the gender does make a difference, because I felt like uh maybe if it was a male certain I guess so emotions could be better understood by them, through my communication (…) but I think right now after you know, when I'm undergoing a treatment I actually realised that gender doesn't really matter because, because I think the therapist they are trained in the skills to really understand emotions and the perspective from both males and females, so I think at this stage I don't really feel that the gender of the therapist is any problem at all." (Lines 576-590)*

However, therapists' gender was reported to be a very important aspect for Jon treatment's experience as he reported lack of affinity with male staff:

> *" (…) let's say there was fifteen members of staff, it was two men, um none of which I got along [laughs] with, um because they were very sort of manly like football 'arrr' all this (…) he [other straight male inpatient] was like very close to all of the men therapists, the men nurses and therapists, they had some sort of banter and like bond and stuff that I definitely didn't have being gay [laughs] (…) it was like a football type of lad [the other male inpatient], so he got along really well with all other men and the men were sort of more I guess, a bit more biased, um like focused more of their energy on him, because they had more in common with him, yeah." (Lines 834-839; 1251-1255; 1259-1262)*

For this reason, having a female majority staff while receiving inpatient treatment turned out to be beneficial for Jon. However, he pointed to the possibility of discomfort for other males with a preference for males' therapists:

> *"I guess it's because like gay men are seen a more, typically seen as more feminised, um so yeah, it felt strange being a man, um but I've always felt more comfortable with*

> *women, so like on the ground it wasn't that bad for me in terms of like interacting with people, but if I was a straight male in an inpatient hospital when the majority were like straight females, it would feel really, I'd imagine that it would be really weird, because you have no sort of male company, um yeah." (Lines 1267-1275)*

Jon also reported feeling more understood and validated by female GPs:

> *" I'd always requested a female one [GP], because she was generally nicer, whenever I had any of the three men, I don't know if was isolated just to them, but um when it was to do like with mental health it was very much just like 'oh you will be fine, get over it' like, men up and all this' and I was like every experience I had with a male healthcare professional has been exactly the same, just 'men up', like 'you will be fine, like grow some balls' so that sort of stuff, it's always been the same, I don't know if it's my bad experience [laughs], but um it's always been the same." (Lines 887-888)*

However, Jon reported that younger age would result in more understanding, which in turn would make healthcare professionals' gender irrelevant:

> *"Yeah how can they like understand like, can would that mind set like 'man-up' how they can try to understand me being younger, in a more progressive society like [laughs] when they were growing-up it was very, very different like um, but if it was a younger male, a hundred per cent I wouldn't mind, I feel like they would be more understanding." (Lines 923-928)*

Treatment setting

Most participants reported preference for personal therapy as opposed to group when given the choice for several reasons. For Jake for example it was because he did not want to be in a group composed of mostly of females:

> *"(…) personally when I was seeking treatment hum was only offered individual therapy, which I think it'd probably be my preference anyway (…) knowing that I'd very much likely be the minority, hum as a man, that would be quite hard." (Lines 728-730; 734-735)*

While others like Sam reported that group therapy would not address their needs as a male:

> *"Hum, I didn't feel comfortable, erm I didn't feel like it was a setting for...that would benefit me to uh I didn't, yeah I felt like I wanted to speak about my own situation, my own outcomes, and it's uh it might get distorted in a group setting, uh yeah, that's, it just didn't feel it would work for me (…) probably would have felt I don't, I feel like I was maybe different to females, and uh I didn't want, I felt like the help that, the help wouldn't be, it wouldn't be appropriately tailored in relation to me and my situation, um if I was sat with the group of females, maybe I thought about my mum and I felt like it was just a different situation, different requirements." (Lines 382-386; 396-402)*

Peter flippantly reported that group therapy could be seen as a dating setting for a heterosexual man surrounded by several females:

> *"… [laughs] yeah I went to group therapy, but I do a silly little joke about it, which I will save you the terror of, but bottom line I went to group therapy because I just been dumped by a girl and when I went to group therapy was me and fourteen girls which as a heterosexual man with quite a few vulnerable girls around, it was more like speed dating than group therapy." (Lines 844-850)*

However, he added that he did not think gender was relevant in the group, but he disliked the group’s focus on changing the environment rather than the individual:

> *“I also think um as well there’s sort of the tone of it was very, the tone of it was about trying to change the world rather than changing the person, it was all about how things are really difficult, how we should get rid of calorie counts on menus, we should get rid of diet adverts, we should get never talk about exercise, whereas actually my kind of view with recovery is actually like you are not going to change the world, you can only change yourself, so learning to deal with, there are going to be calorie counts on menus, how can you control the controllable rather than expecting everybody else to change for you.” (Lines 906-917)*

Treatment strategies and benefits

The participants reported several treatment strategies they found helpful. Some participants described goal setting as helpful strategy during treatment and recovery, as described by Ted:

> *“I guess they set me goals and stuff which was obviously quite good to like if like they say like ‘achieve that weight then you can do stuff’ do you know what I mean, as well as like trying to get to the nucleus of like what was wrong and things and counselling and stuff (…)” (Lines 839-843)*

Also, several participants described their increase in food knowledge as helpful, as exemplified by Sam:

> *“(…) learning things like portion control, you know again it was so much of this, this sort of learned behaviour, adopted behaviours, it was almost like my therapist they had to take me almost out of myself to look into what I’ve been doing and even just basic*

> *stuff of how much I was consuming, what it was an acceptable portion of a meal, like thinking you know, at dinner I had to come on two plates and crazy things like this (…)" (Lines 1016-1027)*

While Mike described that therapy helped him to integrate information:

> *"I'd always said that my one to one therapy, the CBT-e, I kind of knew everything and what they did, they almost pulled a string around it and tightened all in together, because I had this knowledge here, that knowledge there, this knowledge over there, this about that, but it was all loose, and what they did they helped reel it in." (Lines 917-921*

Others reported that therapy was beneficial to understand ED behaviours and their triggers. Jake for example reported benefiting from different approaches, such as exploratory and behavioural focused:

> *"(…) I had another course of therapy again, hum same CBT hum it was probably more just kind of a refresher, it was a different therapist, hum and probably a little bit more behavioural focused, I think the first course I had it was much more 'let's understand what's going on, what was driving all those behaviours', I think on the second course it was much more 'how we can actually do this into practice and change behaviour', hum and after that it has been pretty good." (Lines 108-115)*

Additionally, Sam reported being treated by multidisciplinary team as positive:

> *"I thought it [holistic approach to his ED treatment] was massively helpful, and I thought there was, the thing I liked about, I feel like it sort of acknowledged that uh no one sole*

> *therapist or doctor has all the answers, so it was a process of again sort targeting different angles." (Lines 408-411)*

And he also suggested remote sessions as potentially helpful during his treatment:

> *"(…) maybe sort of video to be able to chat like this, to have to, to have sort of more, to have immediate contact, uh particularly when maybe when you are going through a downtime or a low or you slipped up, maybe to have this sort of zoom dialogue could have helped at the time a little bit more, but again like I have to say like I feel like I got the desired results in the end and I'm very grateful and very thankful, so it's hard to criticise too much." (Lines 430-437)*

Treatment difficulties

Participants reported several difficulties they faced during treatment. For some, the change from not eating to eating was stressful, as described by Jon:

> *"(…) um, so before I went to the hospital um I never ate anything other than bread, chips um sweets and just like chicken nuggets, and that's like I can't stress that was all I ate up until I was fifteen, um it's not until I went to the hospital where I had my first fruits, my first vegetables, my first sausage, my first pizza, my first anything like other than cereal, I ate cereal quite a lot, um so for me it was very stressful, how I first ate peas there, sort peas always scared me because they look really weird." (Lines 391-399)*

While for others like Peter, no perceived benefits from treatment acted as a treatment difficulty:

> *"I think certainly something that I always say is one of the things that putted me off getting treatment was that everyone kept on talking about taking the anorexia away, no one talked about giving anything back, it was always negatively framed, rather than positively, so of course I'm not going to fuck engage in treatment, because I've got nothing to gain and everything to lose…" (Lines 1112-1119)*

Mike reported therapist' lack of ED knowledge as leading to needleless prolonging his treatment:

> *"(…) the CBT, the woman [therapist] didn't have a great deal of understanding around eating disorders, so I think that's why it [recovery] took so long…so again it was right, I was very unwell, but if she'd have…if there had been more knowledge, I don't say if she was doing it now it would have been a very different situation, but back then there wasn't as much knowledge around eating disorders (…) and I think that…that could have been detrimental really." (Lines 1235-1245)*

While for Ted change therapists during treatment was unhelpful for his recovery:

> *"(…) I felt safe and comfortable in their like talking to them, but obviously they left, saw someone new and then you got to start from the beginning I think and that just didn't really help." (Lines 1024-1036)*

Peter also reported appreciating use of sense of humour rather than focusing on negative aspects associated with the ED's experience during treatment:

> *"I also think as well I don't want to sit in the room and listen about people's you know terrible times, I prefer to have a laugh, which is why again this is a shame, but I'm actually creating a comedy course at the moment aimed at people with eating*

> *disorders to try and teach them stand up as a method of recovery to try and associated recovery with some positive rather than negative." (Lines 884-890)*

While for Amal, perceiving therapy as dependency as barrier to engage in treatment:

> *"(…) if I were to seek therapy you know, they would have to give me the steps and the path to get into good right, and if at any point um, if at any point I can't see them [the therapist] or something happens, then I'd feel utterly lost, um and also when you complete the treatment when you're fine, who is to say you won't relapse again and then that relapse means you need to go over that process again with someone again." (Lines 905-913)*

Self-help strategies

Some participants also reported self-help strategies they found helpful for their recovery; for some refraining from measuring their weight was helpful, as exemplified by Mike:

> *"I weigh myself, I was weighing myself pretty much every day, I had to get rid of my scales, and when I got rid of my scales, I'd use an excuse to go and see my mum and dad who used lived across the road, and if I was in a shop I'd pull out the scales off, off the supermarket shelf and stand on them, even at the doctors I'd ask to weigh myself…" (Lines 264-269)*

While Jake reported using material from previous treatment to deal with his ongoing recovery:

> *"(…) at the moment I got my stuff out from when I did my last course of therapy and I'm just a little bit more conscious of them and that's enough for me." (Lines 1019-1021)*

Additionally, Dan mentioned that deleting social media due to the emphasis on food content and calories displayed there and using meditation apps had been helpful while he waited for his specialist treatment:

> *"I started to find other ways, um for example I deleted, this week I deleted social media for a couple of weeks just to clear my mind, um Tik Tok, don't know if you heard of Tik Tok...there was a lot about diet culture and food that I was obsessed with watching and so that's deleted as well, um because you know there's a lot of health baking, what you ate in a day and these videos of what to eat in a day and how many calories, 'this is what I've eaten today' and stuff like that, so I've deleted that and then I've got the app called headspace which is really, really good, because it's a kind of a meditation app, so I'm doing that every day, so obviously there are things that I'm doing on my own, individually to tackle it, but yeah, so, so you know I don't mind holding on for a little bit longer." (Lines 845-853)*

Similarly, although Jake reported not believing social media causes ED symptoms, he acknowledged its role on maintaining ED behaviours:

> *"(…) it really annoys when people go 'oh social media is causing and Instagram and things like that' and I really don't think it is, eating disorders I think have a function which is much, much deeper than that, I think things like Instagram and social media and things are probably catalysts to eating disorders, they keep them functioning and going on." (Lines 492-497)*

Power in treatment

Participants described several instances related to their agency regarding lack of choices in treatment. Some participants reported they would have liked longer treatments as exemplified by Jake, as he believed it would have helped him to practice and get used to behaviours learned in therapy:

> *"I do feel like both courses I had probably have not been long enough...hum but even something like four or six sessions...but then on the flipside I'm also between my first and second courses of therapy I trained CBT myself [laughs], erm I also know that there's probably never a perfect point of ending in therapy (…) I supposed it would've really kind of helped me to embed the behaviours and kind of getting used to being different." (Lines 981-986; 991-992)*

While Jon reported having no choice over continuing at the hospital he was receiving treatment due to his age:

> *"I didn't want to be discharged, I wanted to stay there because I didn't feel like I was healthy enough to leave, um whatever that was just me wanting to stay there because it was nice or like or not, um but I didn't want to leave." (Lines 704-709)*

While for Dan, having access to private treatment choices, resulted in receiving his first round of treatment fast:

> *"The doctor just said 'I'm going to be honest with you, you know, you can get seen fast if you do that private route' and so I've you know...I just started to get on with it, because I wanted you know, specially then I was just more desperate to speak to someone …" (Lines 833-836)*

Geographical area was also mentioned by some participants as influencing treatment quality, supposedly due to differences in healthcare budges according to boroughs, as reported by Mike:

> *"… [my county] has a very strong eating disorder service; I've got a friend who lives 15 miles away from me, he is in a different county, and then at the (name omitted) side, the eating disorders service is nowhere near strong, so I think it's a post code lottery the support that you get." (Lines 1255-1260)*

Finally, Ted had a choice of receiving treatment at home as opposed to being hospitalised, because his mother took leave from work:

> *"I remember that I heard whether I go to the inpatient unit or go back home and like try to recover at home and I think like thankfully my mum basically gave up her job um to like look after me back at home for quite a few months yeah." (Lines 453-457)*

Agency on recovering

Most participants emphasised the role of self-agency in recovery, as wanting to recover was reported to be a crucial aspect, as exemplified by Sam:

> *"(…) ultimately the onus had to be on me you know, you can only really help yourself and you know, you can have the guidance, you can have people pushing you in certain directions, but this ultimately got to come from you as well" (Lines 412-415)*

Moreover, several participants reported recovery as an ongoing process and not destination, as reported by Jon:

> *"(…) I don't think eating disorders ever go away um ever, anyone I've spoken to um still thinks about it all the time, like whatever I go on the scale I think about it, um whenever the number goes up I think about it, not that I'm really bothered, but I still think about it."* (Lines 1161-1169)

In this subtheme, participants described several aspects associated with their treatment and recovery they found helpful and unhelpful. Among the therapists' characteristics, most participants did not report therapist's gender as relevant, despite some descriptions that associated warmer attitudes with female therapists, which were described as sometimes helpful for the therapeutic relationship. However, another participant reported a dislike for therapists they found too caring, expressing a preference for more direct and female therapists, which he linked to being gay. Moreover, a younger age was described as being more important than the therapist's gender, due to beliefs that younger clinicians would deal better with gender diversity. Additionally, some men reported preference for a male therapist at the beginning of their treatment, although gender became irrelevant as the therapeutic relationship evolved.

Moreover, several participants preferred individual therapy over group therapy as they believed a group would not cater for their needs because of their gender, while others would have preferred the focus of the group to be on self-agency and the use of comedy during recovery. Regarding the challenges of treatment, difficulties overcoming not eating, perceiving no gain from treatment, therapist's lack of ED knowledge, and change of therapists during treatment were reported to be unhelpful, while setting small goals and rewards, increasing food knowledge, integrating information, use of multidisciplinary teams, remote sessions, learning how to apply strategies in practice, and understanding their ED triggers were mentioned as helpful. Power of treatment regarding lack of choice in relation to aspects such as length were also reported while wanting to recover was reported as a crucial aspect of recovery. Some participants also felt that recovery would never be fully achieved.

3.3.3.4 Triggers

Participants reported several aspects they associated with onset and maintenance of their EDs, such as perceiving the symptoms as a way of coping, lack of necessary knowledge to make healthy food choices, feeling their body was judged by others, the consumption of large amounts of food growing up, and the impact of the COVID-19 pandemic.

Coping mechanisms

Several participants reported their symptoms to be associated with coping with difficulties. Jon for example reported associated ED behaviours with fearing changes of growing-up:

> *"I was scared of the changes (…) the [therapist] wanted to see like if I was like stunting my growth, um but to me it was like I want to stay this way, I want to like be little [laughs] I don't want to grow up, yeah." (Lines 124; 127-131)*

While Peter associated weight-loss with a solution to his problems:

> *"(…) I always thought that it was about getting down 'x' amount of weight and almost when I got down to that weight everything would be uh, everything would be sorted, everything would be fine, I would be confident, I would uh be attractive, I would be successful, I wouldn't be lonely uh but obviously that never came." (Lines 77-82)*

Moreover, trying to control aspects of life that felt out of control was also mentioned by some participants as playing a part on their ED onset, such as Mike:

> *"(…) I was struggling, life, my life was unravelling faster than I could ravel it back up, that's the best way that I got to describe this, the only way I could control it, was what*

> *I put in my mouth, so I just basically went into starvation mode, I just started to starve myself…" (Lines 101-102; 116-126)*

While for Jake excess of weight was a way of not dealing with his sexuality:

> *"And looking back I've always wondered if it was probably a way of keeping the world away from me, hum so I'm also gay and it took me probably losing weight to come to terms with that, whether the weigh was actually like a physical barrier between me and the world I don't know" (Lines 162-166)*

Amal associated his BED's onset with a way to cope with loneliness:

> *"(…) but I'd find myself eating more and more, maybe that was to compensate for the loneliness, maybe it was to try reignite or reinstall some of the memories, so that was the start of the binge eating if you like (…)" (Lines 87-91)*

While Sam reported that ending a long-term relationship was associated with triggering his binge-eating:

> *"(…) once we broke up [with fiancé] that's was just like, it was just being allowed, everything was allowed to sort of explode to that point, I didn't have that filter anymore and I almost, I sort of, like embraced and run into head first these indulgences, uh and my weight ballooned (…) I was having more and more episodes of just inexplicable eating, both junk food and a lot of sugar-based stuff, and that was formulating, and that was just ninety-five per cent of my diet (…)" (Lines 51-62)*

While for Dan moving from his family house made symptoms worse:

> *"(…) then I moved to London in July, erm and so I wasn't with my family anymore and stuff, um and then really, you know it can get quite ([bad]…" (Lines 56-58)*

Lack of food knowledge

Some participants reported lack of food knowledge as triggering their EDs. Jake for example stated that was not aware of food nutrition and portion sizes to maintain his newly achieved low weight (weight-loss was a by-product of accompanying his mother to Weightwatchers), as a trigger for binge-eating's and purging's onset:

> *"I had this sheer panic of like I had no idea normal eating was, the normal eating I knew was for an eighteen stone man, not for the eleven stone healthy weigh person I found myself at, and I had no idea what to do, hm so I found myself starting to eat the portions I always had been used to before I lost weight, hum gained a little bit of weight, freaked out and then realised actually I could do this, like I could be sick…this way to manage that." (Lines 252-259)*

The body is judged

Moreover, Jake, Dan and Peter mentioned performing in the theatre as relevant to their ED's onset, due to the strong focus this industry gives to body image and the stress resulting from it, as exemplified by Jake below:

> *"(…) and then at the same time I was also studying musical theatre and I think in performing arts that is obviously so much pressure on body shape, size, what you look like, it's your whole image hum and that kind just really concrete, but I guess gave yeah concrete and solid foundations to eating disorders to just really flourish." (Lines 47-52)*

While others reported that feeling validated by others through their bodies as triggering their EDs, such as Mike:

> *"(…) but if I'm beautiful people will love me you know, if I used to when I was younger, if I walked into a room and everybody turns and looks at me, it gave me what's the word, not credibility, but it gave me something, it gave me a reason, and I think that's where eating disorders came in…" (Lines 709-713)*

Moreover, expectation of having the body judged by others was reported by Dan as maintaining his current ED behaviours:

> *"The fact that everyone has seen that I've changed, and then they're going see that I changed back and stuff like that you know, and being treated differently I guess and being seen differently is not...and not a tall you know, toned, lean person and things that stigma, you know that thing about having like a good body." (Lines 762-766)*

Similarly, Joe experienced his body weight being judged by others and perceives other people judging him as abnormal.

> *"You know, I know it sounds strange, but when you are fitter, when you are better, you know, people like you straight way, but when you are overweight they don't, they like, they pretend they do, but inside they...they are thinking you know, you are a freak" (Lines 242-245)*

Joe also judged himself as abnormal when comparing his body to others:

> *"Like looking at them, like you are a freak and you know everybody else is normal" (Line 345)*

The role of family and food in childhood

Also, most participants described excessive eating practices in their families growing up as described by Amal:

> *"they [family] don't force you to eat, but they kind of make you eat and if you don't want then you can just say no, but otherwise they believe it's custom to give you know, you should give and give and give" (Lines 1235-1244)*

Amal also added that such frequent practices could then result in a lack of ability to distinguish eating to satiate hunger or beyond feeling satisfied:

> *"…because you can eat a full meal and then go to someone's house [within the family] and have another full meal, so maybe there's no that indicator to say when is enough, enough in your head, because of the way you've been raised, maybe…" (Lines 1251-1255)*

Peter also reported growing up with an excess of food and that food was used to show affection in house:

> *"I think everyone in my family has disordered eating, I know that as sure as shit, um but whether they had an eating disorder I mean, what I mean by that is food was always fucking around in my house, there was you know, you couldn't go five minutes without people talking about food (…) but there were always chocolate or sweets or you know stuff being shoved under you and I, that again I suppose came from a place of love." (Lines 392-410)*

Covid-19 pandemic lockdown

Four participants (Sam, Dan, Adrian and Jake) mentioned lockdown as trigger for behaviours, cognitions and feelings associated with their ED. Dan and Adrian for example reported social restrictions due to lockdown as a trigger for the onset of their ED symptoms:

> *Dan: "(…) then I started running and lockdown kind of kick started it, I was running 5k every day, built that up to a half marathon, I was running probably about 25 kilometres a week, and then doing CrossFit which is like strength training, then I joined the gym and stuff, and then my general understanding of food you know, I was just eating well, um and to be fair the first couple of months, maybe like March, April time I enjoyed it, um and then it kind of takes its grips on you more and it's hard to get out of…" (Lines 451-458)*

> *Adrian: "(…) so I think for me food became a way of escaping, because, partly because of the lockdown and everything I was able to go and just sit by myself and eat (…)" (Lines 50-52)*

Other participants also mentioned the lockdown restrictions as leading to worries that their recovery could be at risk as described by Sam:

> *"(...) during this COVID it has been terrible you know, COVID, biggest problem with COVID is shutting down gym, gym was central to my life and also building these sort of the offshoots of that, so gym, sleep, eating well, vitamins, supplements, all of these sort of ecosystem, so when you take one thing away it can all fall apart, uh so I was really scared about that, worried, but I've been doing a lot, I've been doing running outside (…)" (Lines 1057-1064)*

In this subtheme, participants identified several triggers associated with the onset and maintenance of their EDs, such as coping mechanisms to deal with negative emotions arising from a diverse range of contexts, which included not wanting to grow up, loneliness, feeling no control. and not dealing with sexuality. Also, participants reported lack of knowledge regarding food choices and portions, feeling the body was being judged by others and themselves, lockdown, and growing up in a family where food was consumed in excess and used to display affection as triggers for their EDs.

3.3.4 Theme 4. EDs are not a part of men's reality

This theme illustrates how EDs were reported as not forming part of men's day-to-day reality and awareness. Participants reported perceiving a general lack of ED information relating to males, which comprises the subtheme: 'Information about men with ED is not shared.' Participants also reported a lack of discussion about their own experience of EDs within their personal relationships, including sharing barriers and facilitators, and the benefits of sharing, which is addressed by the subtheme 'Men with ED don't share'.

3.3.4.1 Lack of ED information about men

This subtheme illustrates males' perception of a lack of information about ED in males, which was associated with lack of awareness, potentially resulting in the perception of a higher occurrence of EDs in females than males. It was also attributed to stereotyped ideals of masculinity that males should be strong and also to a general lack of exposure of EDs compared with other mental disorders.

Dan for example reported a lack of general ED information and awareness in males:

> *"(…) but you know I've looked into it (AN) more, especially in men, and I'm quite interested in it because there's a lack of…um…of information I'd say, maybe an awareness for instance in males you know, and how people talk of it." (Lines 200-203)*

While some questioned whether the knowledge of higher ED incidence and prevalence in females could be due to more discussion of ED in females rather than reflecting the reality:

> *Amal: "I think, when you talk about eating disorders you know, I can remember throughout the whole of high school and you know, even going into university, you hear a lot about uh you know women having eating disorders, which is quite common and maybe it is just because its more spoken about, maybe it's not necessary that you know, occurs more in women, it's just that yeah like I said it's just more spoken about." (Lines 28-25)*

While other participants suggested that stigma and masculinity ideals such as that men should be strong could be associated with lack of discussion of ED in males, as reported by Dan:

> *"(…) it's [EDs in males] not talked about, it's unusual, hum it's rare you know, people…it's not talked about enough you know, it's not shared much hum there's not much, not lots and lots of information about it, hum well you know obviously is getting better, it's a kind of a stigma around male mental health in general you know, hum it has always kind of been 'men up, get on with it' hum there's always been that weird stigma around that and so I guess with eating disorders, even more being so unusual about the eating and rare kind of not talked about and very much mental health condition also, there's this kind of stigma that men don't have them and that you just get on with it, you know, you just carry on." (Lines 1086-1096)*

Moreover, Ted reported that there is not only a lack of discussion of EDs in men, but also in general when compared to other mental health conditions such as depression:

> *"I think eating disorders in general, like people don't want to talk about them, I think people, it's come quite a long way with stuff like, even like I don't know, depression and things like that are talked about a lot, a lot, a lot more and obviously that's brilliant um but like eating disorders are definitely like still a bit like of a grey area, I feel like people don't talk about it very much, there's a sort of like awkward thing, sort of secretive like, I don't know, just that's definitely the case for a lot of people." (Lines 1253-1261)*

Together, these reports reflect participants' perception that there is a general lack of ED information featuring males, with some questioning whether the higher prevalence and incidence of EDs in females could be due to males not talking about their EDs. Masculine ideals of strength were also mentioned as possible reasons for EDs in men not being talked about as men are expected to be self-reliant and not needing to seek help. Also, some participants reported that EDs are not as visible as other mental health disorders such as depression.

3.3.4.2 ED is not a men's subject

Lack of discussion about EDs in men was also reflected in participants' personal lives, as they reported several difficulties in talking about their ED experiences.

Sharing barriers

Several participants reported feelings of shame and embarrassment in sharing their ED experiences with others, as described by Ted:

> *"(…) basically I just sort of told them [friends] uh… like I was pretty embarrassed and I sort of didn't really want them to be there and I remember it just because like I felt*

> *just a bit ashamed by it and stuff, and they were um they were great like, they are brilliant like especially when I went back to school later on they were brilliant…" (Lines 709-717)*

While less shame was associated with sharing with someone not close, such as his GP:

> *Dan: "…speaking to a GP about it, someone that doesn't know me, umm then I definitely feel much less shame about it, but speaking to someone who I do know, like a family member um then I would feel a bit more shame about it…" (Lines 563-567)*

While Adrian reported stigma associated with mental health and his male gender as the reasons he was embarrassed to disclose to a friend he was seeking help:

> *"(…) initially I wanted to ask a friend along [initial GP appointment], but I think I felt it was a bit embarrassing, because I guess the stigma for this kind of mental health issue especially in men can be a bit hum yeah, it can be a bit difficult even for men to sort of like tell a friend 'you know this is what I'm struggling with' so I went on my alone, so I went to the appointment by myself, I went alone, I got a referral and I sort of went through treatment alone." (Lines 134-141)*

Perceiving body parts as abnormal as also reported by some participants as a barrier to share aspects of their ED with other males. Joe for example, described felling abnormal as he considered his chest to have an appearance of a woman's chest:

> *"I was, I was, I was strange, my belly was ugly, I had woman's, woman's breasts, and I didn't like it, I didn't like to speak to people about that, you know like, you feel abnormal, like you have breasts the size of a woman, like you don't want to talk to your friend about that." (Lines 636-639).*

While Max also reported dissatisfaction with his chest:

> *"Uh I think I just started to do it because um I think I was unhappy with how I looked, uh and I wanted to see if I could get like slim, slimmer and stuff like uh maybe my chest area, like um a male, like male breasts or male like the appearance of the pectorals I guess they are called…" (Lines 195-199)*

While, Jon reported feeling abnormal as a male with AN, but because of his gay sexuality where he did not feel comfortable sharing his ED with straight men:

> *"[I feel] like a fish out of water, like I don't feel like it's, um I don't feel like normal for having it (AN), I feel like I'm completely abnormal, so I'm gay um it's definitely something that you do not talk about to like straight men like [laughs], like straight men like you just don't talk about it, because you'd be looked down upon, if for a male you had a like an eating disorder that was very feminised (…)" (Lines 1180-1186)*

Thus, feeling abnormal for Joe and Jon was associated with having aspects that are considered to belong to women (woman's breast for Joe and AN for Jon).

Moreover, While Amal reported perceiving ED as a weakness as a barrier to share about his ED with partner:

> *"I'm in a long-term relationship, I didn't even really tell her, because you know, I think it [ED] also shows sign of weakness you know and that's not really what you want…" (Lines 304-307)*

Also, change of other people's perception and its potential consequences, were mentioned by some as a barrier for sharing for some, as exemplified by Adrian:

> *“I think because that’s at least from a guy’s, from a male’s perspective it’s just to oh, there is always this concept of having to maintain this certain image, this certain perspective that people think about you, so obviously I don’t want to, you try to not tell people about these kind of struggles, because you are not too sure about what people would change in their perception about you after.” (Lines 670-676)*

Some participants also reported as barriers other’s lack of understanding, which was associated with others not seeing a reason they should have problem such as an ED, as exemplified by Peter:

> *“I felt that if I you know, sort of try to say ‘I got a problem’ it would be very easy for the argument to come back as well, “White middle class cisgender man who is living a very comfortable life, what the fuck is your problem, you have no reason to be mentally ill’ (lines 538-543).*

Still, for Jon lack of understanding was associated with gender, as he believed other males are not able to understand his experience of EDs:

> *“(…) they [other men] just do not understand, like my dad when I was going through it, he pushed me so hard to go to um to an army boot camp, like he would not, he didn’t want me to go to the hospital, he didn’t want me to have therapy, he was convinced that the army boot camp would fix me, um and so it’s almost like there’s a general consensus of all the straight men I spoken to, um ‘oh you just need to go to a boot camp.” (Lines 1194-1200)*

While some participants added that other males would not understand EDs experiences, unless they experienced it themselves as reported by Dan:

> *"(…) obviously an eating disorder in males...with men specially isn't really talked about and most men don't understand it really, unless they've experienced it, and so talking to them about it it'd be...it's much harder, because there is a different stigma around it." (Lines 532-539)*

In addition, some reported believing that EDs had to visible in their bodies in order for them to share about it with others:

> *Max: " (…) because I look normal I think, I think I look quite, I don't look super skinny or anything or super fat, so I'd feel a bit like a fraud (…) Because like if I wanted to discuss eating disorders with other people I feel like I'd need to have demonstrated that I have one or I had one, I'd need to be very skinny or I'd need to be very large, yeah." (Lines 772-781)*

Similarly, Peter also mentioned feeling like a fraud regarding his AN experience due to not receive inpatient treatment and not looking anorexic:

> *"I never been 'inpatiented' so it kind of made me feel like a bit of a fraud and then people kept sort on saying to me things like 'you don't look anorexic'…" (Lines 335-340)*

Similarly, Joe reported that that ED itself was not seen by others. Consequently, others were unable to acknowledge his inner struggles and the challenges to overcome the BED and the weight's excess:

> *"I felt more like labelled because I was really fat, not because of my...because in the end people don't really see your eating disorder, they see you are overweight, they see you are fat, you know, they see your image. But they don't see there's a problem*

> *behind that, they don't see like why this person eats so much, they just see you like, alright, this person is fat, you know, that's all the see. They wouldn't label you for your eating disorder, but they would label you for being fat." (Lines 1115-1121).*

Some participants also reported not wanting ED to define their identity as a barrier to share after recovery, as reported by Ted:

> *"(…) even when I first came to uni when I was eighteen, it was sort of like, I didn't tell anyone at uni because I was like, one it was over and I was okay, it's almost part of my old life, I don't really want to you know like have that label, so I was just sort first came to uni and just like sort of didn't want to tell anyone." (Lines 1143-1151)*

Beliefs that by focusing on an issue makes it bigger was reported by other participants to be another barrier to sharing about their ED:

> *Jake: "(...) but I've also asked them not to probe, because that can sometimes make it worse (…) I worry if I give so much thought I'd lose those things, because that thought is so I guess tempting I don't want to go there." (Lines 1010; 1036-1037)*

Cultural and family background were mentioned by several participants to be a barrier to sharing about their ED. Amal's family for example, does not believe in mental health existence:

> *"I think culturally it's a big thing, because depending on how your family perceive diseases, mental health etcetera, depends on if you want to share you know, because sometimes you could be talking to someone that doesn't understand or doesn't want to understand, then it becomes a point of you trying to convince them versus you just telling them, which was also difficult." (Lines 628-635)*

Also, Amal mentioned difference in generations was also mentioned by as a barrier to sharing:

> *"(…) especially when you look at your parents who are thirty, forty years older than you, so it's gone, whatever they learn in school was completely different, and whatever they experienced in life is completely different." (Lines 646-649)*

Similarly, Sam also mentioned background and culture as a reason for parents' difficulty in understanding his experienced with EDs:

> *"(…) he's [dad] not emotionally aware enough, he's from a different background, where you perhaps you don't have time for to have eating disorders, when you are not entirely sure where your next meal is coming from, so it's just is, so it's so foreign to his culture and his conditioning that I don't think he can truly understand it." (Lines 584-589)*

While for Max already existing difficulties with father as a barrier to share about ED experience:

> *"(…) my father is quite an imposing person, like he's much more extroverted than the rest of the family, hum he's also a bit, I'd say irritating at times, like he's too, doesn't, he crowd's people out sometimes when he speaks and, so I don't particularly enjoy always be around him, so it's like this tension there between how his behaviour and wanting to take advice from somebody like that if you see what I mean." (Lines 243-249)*

While for Joe difficulty in sharing with family was attributed to beliefs that his family would not give him an impartial opinion, possibly not to hurt his feelings:

> *"…because you know they are lying, you know, so you can't consider their opinion, so that's why I wouldn't talk to family, because they always gonna say "you still look good,*

> *you look good, you look good", you know you don't look good, that's bullshit!" (Lines 775-779)*

It was also suggested by some participants that EDs are not an interesting topic, hence not worth sharing it, as stated by Amal:

> *"(…) you just kind see it [ED experience] as other personal matter that I needed to attend at the time, but it's not anything interesting, it shouldn't be a basis of a conversation" (Lines 324-327).*

Some participants reported believing that topics such as EDs and related topics (weight, body shape, appearance) are generally more discussed among females and by females, as stated by Dan:

> *"I think maybe because weight and fitness and body, well weight and fitness and weight loss is kind of associated around women more, and so when a female would say to me um I guess they, they kind of understand it more"* (Lines 691-695)

Or gay men rather than straight men as stated by Jon:

> *"(…) again with stereotypes, but like the typical gay male um will like kind be a bit more not preoccupied, but be a bit more conscious of their body and sort of feelings um than other than straight men for some reason, I don't know why, um they are more comforting, they give more of an empathetic approach…" (Lines 1217-12222)*

Sharing facilitators

Participants also reported several aspects that facilitated sharing their experiences with others such as believing other shared their experiences. Jon for example, that felt comfortable sharing his experience with other gay men due to the shared experiences between them:

> *"I haven't talked to many men about like with eating disorders about it, but um the ones that I have they've all been gay, um they've always had sort of similar experiences to me, um there was a few, there's two straight guys in the uh in hospital, but they were the ones that were like PRS [Paralysis Refusal Syndrome] so they didn't really speak, um so I couldn't get their opinion." (Lines 1236-1242).*

Similarly, Ted also reported that relating to other men with ED could act as a sharing facilitator, thus it would be beneficial if more men openly spoke about their experiences with EDs:

> *"(…) you definitely need role models and stuff like that because as soon as you see someone else, like coming out and talking about it, if you got a problem you'd think 'ah, it's not actually that bad' or like 'look they said it and like they are happy to talk about it, so I'm sure I can as well' sort of thing (…)" (Lines 1305-1310)*

Ted also believes that more talks about ED in men can facilitate other men's sharing their ED experience and also increase ED knowledge in general, aiding symptom recognition:

> *"…some of the runners they, they openly say to like, will talk to me about it [their ED], but they would never like talk, because obviously I put something on my social media, but they would never want to talk about it to other people, um and I guess just like yeah, just a bit of an embarrassing subject for a lot of people still." (Lines 1261-1267)*

Similarly, relating to other men EDs in the media were reported by some participants to help with increasing the awareness that EDs are an issue that can also occur in males, such as reported by Peter:

> *"You know, I've got experience you know, I know the you know Elton John, Russel Brand, Caleb Nichols, A Malik, Fred Flintoff, they all had eating disorders and they are all blokes, so that kind of shock horror men getting eating disorders too doesn't really work on me, because you know I could name numerous celebrities and fucking normal people that I know that just have them, so it is doesn't, it's removed to that you know shock and wow factor" (Lines 1037-1044)*

However, some participants reported a lack of males with EDs symptoms representation in the media. Max for example reported that at the time he was diagnosed he knew about EDs mostly from ED in females represented in the media:

> *"I think it'd [ED's source of information] be like adverts on TV and stuff, but it's mostly featuring young women, but I'm the only one [man] who had an eating disorder in person." (Lines 293-295)*

Despite this, some participants reported that there has been an increase in the number men with EDs in the media compared with previous years and several participants referred to Fred Flintoff's documentary (which shows Fred talking about his struggles with eating, exercising, and concern with his body weight), when talking about men's greater visibility in the media:

> *Jake: "(…) it does feel like there's much more on TV, like there was the thing with Fred Flintoff a couple of months ago, hum, people are much more open to talking about it, so hopefully those things are making an impact hum, but it'd be remiss for me to say either way, because I've not got the evidence." (Lines 839-846)*

Moreover, several participants reported relating to Fred's experience:

> *Mike: "(…) Did you watch the Fred Flintoff…? (…) Yeah, I feel really sorry for him, because I've been there, I've been where he is." (Lines 1384; 1388-1389)*

Dan reported that the documentary helped to reduce his sense of isolation in regards to his experiences:

> *" (…) there was never any male stories or you know stuff until this Fred...this documentary came up on the BBC, and when you look at it you see that the majority of the people who suffer with that are women and stuff like that, and I guess is harder to relate to that you know, because men obviously they will go through the same stuff with an eating disorder, but obviously to related to someone is...would be good, oh you know to, not to...I'd say would you know, not corny or anything, but it make me feel less alone, hum and so I kind of wanted to see that, but there wasn't much there." (Lines 223-234)*

Ted also reported perceiving Fred's documentary as helpful to reduce the stigma of ED in males:

> *"(…) like you see loads of stuff, I don't know if you've seen um, I don't know if you know the cricketer, Fred Flintoff, he did a whole thing on his like battle with bulimia and stuff, so I think it's definitely becoming less of a taboo subject and a lot more of like uh an open thing, which is obviously great, so um yeah, it's good and like yeah to be open to talk about it now (…)"* (Lines 1223-1233)

However, despite reporting an increase in relatability to a man on the media like Fred Flintoff, some also reported surprise that he had an ED due his outgoing personality, sporting abilities and strength, as reported by Ted and Dan:

> *Ted: "I feel like people, like I was surprised, like not surprised because obviously, they are just like, Freddie seems like such um (…) like he's such an outgoing person and like a quite a fun guy that you sort of just think you know, 'he's absolutely fine' so just, I think it was quite big for him to come out and do it because it just open your eyes up to the fact that like anyone can get one do you know what I mean, and obviously males as well (…)" (Lines 1223- 1249)*

> *Dan: "Well I watched a documentary on BBC, you might have seen it um which was about Fred Flintoff living with bulimia 207-208 (…) I've watched that in September time, um and that was when I got interest in eating disorders in males, because um in general really I hadn't spoken to anyone who had an eating disorder, um but…a man sorry with an eating disorder, I've spoken to some girls who had it, so watching that it was kind of you know triggering maybe or you know quite scary, because you know he is obviously maybe stronger than lots of other men…" (Lines 212-218)*

On the other hand, strong masculinity ideals embodied by Fred was reported by Mike to increase the relatability in other men as opposed to other males that might not be taken seriously or gay men:

> *"He [John Prescott]'s a big Northerner, he big, heavy set Northerner, Deputy prime minister, but he was known for making mistakes, saying what he wanted and get his words mixed-up you know, and he was a man's man, and he came out as bulimic, and everybody laughed, 'look at him, he's ugly and fat, don't be stupid', that was about probably about 15 years ago, then Christopher Eccleston, do you know who Christopher Eccleston is? He's an actor, he came open about his anorexia probably you are aware of this, but it was almost 'oh well, he's one of them sensitives isn't he, bless him, he's an actor, and he's a sensitive type, he's probably gay too', erm so that didn't give him much credence, so Fred Flintoff being brave (…) he's a man's man you*

> *know (…) I think there's going to be a shift in the struggle that people like me have to raise the awareness of it, because someone like Fred Flintoff, who's tough as old Brutus and can drink people under the table and drives cars really fast, then anybody can come out without being embarrassed about it." (Lines 1404-1431)*

Similarly, Peter reported not relating to other gay men that display feminised characteristics, unless they also use comedy and displayed agency over recovery:

> *"(…) but I feel like some of the blokes that are around are very feminised, chintzy and fake, it's all of this stuff about 'let's do yoga and realign our chakras' and stuff like that, when it's like I actually know first-hand that they're actually not, how they try to portray themselves on social media, whereas I'm not motivated by this victim mentality, I find that grating and frustrating, whereas if it was people that I could have a laugh with or people that were camp, but you know great, I don't know if are aware of his brilliant about the work of Dr Russell Delderfield, an absolutely incredible academic, he's very open about his own lived experience of eating disorders, but he's engaging, he's funny, cares about other people and I think people like that." (Lines 871-883)*

Sharing strategies

Moreover, among participants who shared their ED experience with friends, some reported feeling more comfortable if they are the ones taking the lead and approaching their friends as opposed to friends asking them as stated by Jake:

> *"I have really like probably a select couple of friends who I will really talk to about it, hum they, they know not to ask, hum but they know that I can go to them if I need help and I do, like during this year hum were things have been a little more difficult I have talked to them about it and said where I'm at and things" (Lines 1005-1010).*

Also, some reported preference to share with friends via text messages as described by Adrian:

> *"I think I realised it's easier for me to share with them now that they are back home, because everything is done through texting, so it's very anonymous, I mean not anonymous like I still know them, but it's easier to tell everything through a text rather than you know, like a face to face voice kind of conversation (…) I think because when you are texting someone you can ignore their replies after that, [laughs] so you don't have to worry about what they think about you, whereas when you are doing like a video conversation you have to think about a reply on the spot." (Lines 795-808)*

Also, several men reported that sharing after recovery was easier compared to when they were going through experiencing it, as exemplified by Sam:

> *"I felt like I overcame it and so speaking from a position of strength and also knowledge and understanding of everything and I felt confident that I wouldn't go to that place again (…)" (Lines 638-641)*

For Adrian it was helpful to have a space to share that felt safe, which he associated with people being open to listen and regularly check on him:

> *"I think I was a bit apprehensive, I was a bit scared, because I wasn't sure what they were thinking, but then again after I started going to the church regularly I realised that everyone there has got their own kind of struggles, problems so you don't have to really feel shy about it and I found the environment was fairly supportive you know, people were very willing to listen and I thought 'oh, this is like a safe space where I can go there, talk about my struggles every week and people there were really willing to listen and even, even on week days you know, they will reach out and drop a text, you*

> *know show some encouragement or you know checking with you and show some concern, so I found that really, really, really good, yeah." (Lines 830-844)*

Thus, sharing with others were described to be beneficial, as some participants mentioned that they would feel less isolated with they had another male with ED to relate to, as reported by Dan:

> *" Erm, this just might be personal for me, but erm I just think speaking to another man about, another person I know who is a boy, hum about that would just generally make me feel a bit better about it, because uhm not knowing any other, you know I know quite a lot of girls you know, who suffer with their eating and eating disorder and stuff, um and I don't know any man who do, and that's just goes to show like you know, and I think just that on its own makes me feel more alone, because…because in terms of my gender, so I just think knowing someone who is a man, who had, who has struggles with an eating disorder would just make me feel less alone I think generally." (Lines 255-265)*

While for Jake sharing with others enabled him to accept himself:

> *"(….) being able to do all of those things [being open with family and friends] and kind of test the waters on how they responded, probably really help me then to be able to really accept myself, hum and helped me as a nurse to be able to kind of own that lived experience as well, now if I hadn't told all my friends and family those years ago I don't know whether I'd be doing that." (Lines 1359-1364)*

And for Dan, sharing with friends led receiving advice from them which prompted his help-seeking:

> *“I remember like messaging the same friend like in May, June like, and this was a point that I was unaware I had an eating disorder but just being extremely down about my body and, not...not because it was bad, but my exercise and my food and stuff and talking about that, but then in July we had a proper chat about it and he was like ‘you need to speak to your GP and call your doctor’, and so I did.” (Lines 310-315)*

This final subtheme depicted the several instances that affected whether participants shared their EDs. The many barriers included feelings of shame and embarrassment, beliefs that men with ED are weak, fear of changes in the perceptions of others, others’ lack of understanding, (in)visibility of ED in the body, not wanting to be defined by their ED, challenges sharing with family due to cultural and family background, generational differences, existing issues in communication, and family bias, EDs not being a topic males know about or discuss, EDs not being interesting topic, and perceiving the body as abnormal. It also depicted facilitators of sharing such as relating to other men with ED in their personal lives and media, and the benefits of sharing, such as reducing their sense of isolation, self-acceptance, and prompting professional help-seeking.

3.4 Summary of findings

These themes reflected several ways in which participants experienced their ED symptoms, including beliefs associated with EDs as a disorder in general, the meanings ascribed to the symptoms, their journey from getting an ED diagnosis to receiving treatment and recovering, and interpersonal relationships, all of which included broader social cultural contexts. These are all discussed in depth in the following chapter.

4. CHAPTER FOUR: DISCUSSION

4.1 Introduction

This chapter discusses the findings of the present study in the light of the current ED literature on males. It then highlights key strengths and limitations, areas for further research, and practical implications for Counselling Psychology. The current study aimed to understand the experiences of males with EDs through the following research questions: 'What are males' experiences of their EDs?' and 'How do males make sense of their experiences?' A qualitative methodology was employed to explore men's experiences in depth. The findings highlighted several themes males with EDs experienced as relevant concerning symptom recognition, treatment, recovery and their bodies, and the significant influence of gender and masculinity norms on all these aspects.

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4.2 Main findings

Theme 1. EDs don't happen to people like me

- EDs as female and not male disorder
- EDs are too serious
- Men with ED are weak

Theme 2. EDs as paradox

- Not eating but gaining (Weight-loss as sport & ED as part of identity)
- Eating but losing (Eating as an addiction)

Theme 3. Steps for change

- Help-seeking
- Diagnosis

- Treatment and recovery
- Triggers for ED

Theme 4. EDs are not part of men's reality

- Information about men with EDs is not shared
- Men with ED don't share

4.2.1 Theme1. EDs don't happen to people like me

The first main finding of this study highlighted several beliefs that prevented males from recognising EDs in themselves, such as beliefs of ED as a female disorder, that they are self-inflicted, and that they only happen to weak people. These findings have been well-established in previous quantitative (Ebneter et al., 2011; 2013; Roehrig & McLean, 2010) and qualitative studies (Räisänen & Hunt, 2014; Robinson et al., 2013; Thapliyal et al., 2020).

However, an additional perception was that of EDs manifesting in the form of extreme symptoms, which did not match their own experience. This seems contrary to findings of males attributing less seriousness to EDs than females (Anderson et al., 2016; McLean et al., 2014; Rodgers et al.,2015; Simpson & Mazzeo, 2017). However, because these studies compared perceptions between genders, the level of severity attributed to EDs exclusively by male participants is unclear. Nevertheless, participants associated the extremity of symptoms with females, laziness, and extreme emotional demonstration. This indicates a significant association of ED extremity with female stereotypes, which demonstrated further the strong effects of attaching female stereotypes to EDs on participants' recognition of their own ED symptoms.

Additionally, participants in this study attributed several other characteristics to the perceived femininity of EDs, such as small and slim body sizes, dieting culture, and psychological and biological aspects such as a ‘feminine psyche’ and fertility functions. Research suggests that the association of specific characteristics of EDs with a certain gender, such as the characteristics of AN such as low weight with females, and of BED and MD such as higher weight and muscle mass with males, were influenced by gender norms and ideals regarding body image, behaviours, and personality traits (Griffiths et al., 2014; O’Connor et al., 2016).

Hence, it could be argued that all these female attributes males associated with EDs are incompatible with Western ideals of masculinity such as strength, stoicism, and self-reliance. Therefore, when the body is viewed as a social instrument that performs masculine ideals of gender (Connell, 1995), the experience of EDs in males’ bodies, behaviours, and emotions seem incompatible with their performance of masculinity. This conflict between ED as female experience and masculinity performance seems to act as a barrier to males recognising ED symptoms in themselves.

This is congruent with males experiencing female stereotypes associated with EDs as negative and stigmatising (Griffiths et al., 2014; Griffiths et al., 2015b), and evidence of lower help-seeking among males who rigidly adhere to masculine gender norms (Rogers et al., 2001; Ridge, Emslie, & White, 2011; Shepherd & Rickard, 2012). However, it is important to note that there are several ways males can perform masculinities, and this talks place within a varying range of acceptance or rejection of what is considered feminine or masculine (Anderson & McCormack, 2018).

This was demonstrated by a study exploring the discourses used by males in pro-anorexia forums, where some males adopted traditional masculinity concepts while others rejected them (Quiniones & Oster, 2019). This study found that males who embraced masculinity viewed AN as a way to achieve more muscularity as it was associated with control through activities framed as healthy, such as sports and weightlifting. While for males that rejected masculinity ideals, AN was aimed at achieving a slimmer body and in general was more associated with female ideals. Additionally, the group rejecting masculinity ideals were more open about their EDs, more inclined to seek support, and more likely to challenge stereotypes associated with gendered body ideals. This suggests that higher adherence to feminine ideals was more helpful for males in relation to several aspects of their ED experience.

Moreover, considering the role of EDs and gender within a critical realist framework indicates that participants' performance of masculinity norms (such as believing and behaving in ways that demonstrate strength and lack of emotional display), does not match their experiences of symptoms as an ED symptom, because they associated EDs with a stereotypical female performance of gender (i.e., crying, despair, dieting, and small bodies). Therefore, within an ED context, such events are perceived by males as female events. Consequently, the empirical layer of reality (experience of symptoms and perceptions and beliefs about gender roles), does not match males' actual layer of reality (symptoms theorised as EDs and performance masculinity roles). Thus, in this scenario, the power structures (real layer) that maintain binary gender ideals and ascribe greater power to the adoption of masculine norms should be addressed, as they seem to be constraining males' agency in construing their symptoms (empirical layer) as ED symptoms (actual layer), due to performing male gender according to masculinity ideals.

Overall, the present findings reported in the theme 'EDs don't happen to people like me' suggest a strong association of participants' experiences with binary ideals of gender, as they linked EDs with females and stereotyped female attributes, leading to a lack of recognition of ED symptoms, possibly due to the performance of masculinities not matching a female disorder.

Moreover, it is evident that labels characterising EDs as a female disorder have a negative connotation for males, possibly because they are antithetical to masculine gender norms such as strength and power ideals. This demonstrates that the alienation males experience from EDs in gender are not only due to the negative attributes associated with EDs, which then become stigmatising, but also to deeper structures that maintain such ideals. Therefore, it could be argued that a systematic marginalisation of males within the ED field could be one of the many factors contributing to such alienation.

Consequently, these findings demonstrate that is imperative to recognise the interaction of boys and men with collective ideals of masculinity in order to understand the role of gendered consequences on health (Connell & Messerschmidt, 2005). It is also important to challenge sociocultural and biological ideals regarding how male and female bodies should look, behave, and function in wider contexts, such as in research (i.e., including more male samples) and healthcare practices (i.e., in sessions with clients and with other healthcare professionals in multidisciplinary teams), to improve males' recognition of EDs and treatment-seeking.

4.2.2 Theme 2. EDs as paradox

Another significant finding of this study was men's experience of ED as a paradox, which included experiences of EDs as sport and identity, and of EDs as an addiction, which is similar to previous research reporting the sense of euphoria experienced by males in association with food restriction, weight loss, and exercise (Leichtman & Toman, 2017; Thapliyal et al., 2020). Previous literature has also found the males described experiencing EDs as a competition to achieve the lowest weight or be the sickest men, which was suggested as possibly being influenced by learned sociocultural values of sports and competition in males (Drummond, 2002). However, the men in this study also described purging behaviours, through vomiting and diarrhoea, as sources of accomplishment and joy. This adds further behaviours to those highlighted by the current literature (food restriction, weight loss, and exercise) that males experienced as a competition.

Experiencing EDs as sport also demonstrates that competition and achievement can be significant aspects for males regarding their experience of ED symptoms and possibly an additional aspect that ED treatments for males could target (Thapliyal et al., 2020). It also demonstrates the influence of gender roles on males' experiences of EDs, as sports and competition could be considered valuable in enhancing socialisation among males and demonstrating masculine ideals of endurance and strength (Drummond, 2002).

Another aspect of men's experiences of EDs as gain was the description of EDs as part of their identity regarding body image (i.e., the skinny guy), behaviours (i.e., I have always done that), and inner self (i.e., the pig that lives inside). These experiences extend from research that mainly highlighted the effect of the ED on certain personality aspects, such as challenging identities of masculinity and normality in males (Thapliyal et al., 2020), or as serving a function, such as increasing acceptance from others (Robinson et al., 2013), as EDs in this study were experienced by some participants as being an integral part of who they are. References to an external entity, such as a 'pig' in this case, could also indicate a wish to escape from behaviours one cannot control (Delderfiled, 2018) or is viewed as incongruent with the ideas they might hold of themselves.

Such findings demonstrate the multidimensional and complex concept of body image as a phenomenon that is influenced by sociocultural aspects and goes beyond the definition of a mental representation of the physical body (Pruzinsky & Cash, 2002). For instance, participants also experienced their EDs as a way of being in the world through the body (i.e., wanting to be the skinny guy), the mental representation of part of the self that is a pig, the inner self (i.e., the pig inside), and ED behaviours used to cope with emotions and the world.

Viewed in this way, EDs are experienced as embodied experiences within an individual that are shaped by social relationships and structures (Eli, 2018).

Moreover, embodiment can be characterised as a way of being in the world, as a sensory experience of the world, and as a subjectivity shaped by cultural and social practices. Furthermore, through the interaction and performance of such practices, embodiment also shapes cultural and social practices (Piran, 2017). This is congruent with research proposing EDs as a manifestation of the body and functioning as a way to relate to oneself, others, and broader social structures, as opposed to ED as a phenomenon that is external and alien to the body, self, and social context (Delderfield, 2018).

Furthermore, experiences of EDs as a gain, through sporting practice and as forming part of identity, might demonstrate that possible strategies to help with symptom identification in males could also focus on these aspects of the disorder, and consider the meaning EDs have for males in view of the potential influence of masculinity norms and other aspects associated with relating to others and the world.

The theme ‘ED as paradox’ also included experiences associated with eating and feelings of loss. These were represented by descriptions of ED as addiction, due to the lack of control over-eating behaviour despite the negative consequences. This echoes the experiences of males in previous research where EDs have been described as having similar functions to an addiction (Petersen et al., 2016; Robinson et al., 2013) and exercising was considered within an addiction model due to its compulsive characteristics. For instance, the latter was described as performed in excess and repeatedly to avoid or alleviate negative feelings such as guilt (Meyer et al., 2011).

However, the present findings build on previous research by highlighting ED descriptions associated not only with the similarity of function between EDs and addiction and the compulsion to exercise but also the compulsion to eat and the compulsion to purge through both exercising and vomiting. A lack of control over thoughts about eating and purging, which were associated with extreme fatigue, guilt, changes in social life, and prospective life projects, are consequences that can also be found in the literature (Boon et al., 2017; Petersen et al., 2016). Moreover, the compulsion experienced by participants applied to several aspects of their EDs and not only to eating and exercising behaviours, as described by previous research (Björk et al., 2012; Petersen et al., 2016; Robinson et al., 2013).

Furthermore, the change in initial perception of some behaviours as healthy to unhealthy, such as in an addiction, was highlighted by several participants. This is also evident in the literature, where the normalisation of ED behaviours that could be perceived as healthy or normal, such as losing weight and exercise, impaired early symptom recognition and help-seeking (Thomson et al., 2014). It is also notable that some males directly compared EDs to an addiction, which could suggest the higher incidence of males engaging in risky behaviours, such as binge drinking alcohol and substance misuse and dependency, compared with females (Courtenay, 2000; NDTMS, 2021). These appear to be viewed as more of a male disorder than an ED, or may indicate that the concept of addiction compared with EDs could be easier understood by others, possibly due to greater common knowledge of addiction.

Overall, EDs as a paradox strongly reflects the influence of masculine gender roles on how EDs are perceived by males (i.e., as manly: sports and competition portraying masculine ideals of endurance and strength), and experiences of EDs as an embodiment of ways to be in the world, experienced mostly as resulting in joy and sense of achievement. Conversely, EDs were also experienced as a lack of control and compulsion, resulting in several negative consequences on physical and mental health, social life, and current and future life projects and prospects.

4.2.3 Theme 3. Steps for change

Similar to some of the studies reviewed previously, most males reported agency in seeking help for their EDs once they identified there was a problem to be addressed (Lyons et al., 2019), while for some participants help-seeking was initiated by their family (Räisänen & Hunt, 2014; Petersen et al., 2016). Notably, help-seeking for all under-aged participants in this study was initiated by their families, replicating another study's findings (Lyons et al., 2019), as some participants did not identify their symptoms as a problem to be addressed. This finding raises questions about ED symptom identification in underage males and their families.

Research has suggested that difficulties in seeking help among young people are attributable to the lack of recognition of a problem by themselves and their families (Thomson et al., 2014), negative stereotypes associated with mental health and help seeking (Salaheddin & Mason 2016), service knowledge, fears regarding confidentiality of services, and embarrassment and difficulty talking about concerns (Booth et al.,2004). Thus, early intervention focusing on young people (Pratt & Woolfenden, 2002) and their parents have been suggested as potentially helpful in improving symptom recognition and help-seeking (Nicholls & Yi, 2012).

Regarding diagnosis, participants reported mixed experiences of either receiving it as a shock or as something they expected. However, the diagnosis for most resulted in making sense of and validating their experiences, which has been suggested in other studies as increasing treatment engagement (Leichtman & Toman, 2017; Robinson et al., 2013). Nevertheless, some participants described several barriers to getting an ED diagnosis, such as the need to visit the GP several times or receiving unhelpful GP advice.

Furthermore, participants associated difficulty in getting a diagnosis with lack of a significant change in behaviour and appearance, which ultimately led to significant symptom deterioration and the need for urgent care. Unfortunately, the latter has also been reported in previous research and has been associated with low heart rate (Leichtman & Toman, 2017), collapsing due to AN (Lyons et al., 2019,) and a suicide attempt in a man with BN and AN (Räisänen & Hunt, 201). Similarly, in the current study, the need for urgent care was also associated with low heart rate and AN. Given the seriousness of AN and its high fatality rates (van Hoeken, & Hoek, 2020), these findings emphasise the need to improve early recognition by males, their families, and clinicians.

Also, the role of vulnerability while seeking help for a second time was reported to result in an inability to disagree with the GP's course of treatment, despite the participant's expertise about EDs and ED treatments. Thus, demonstrating an ability to openly discuss concerns with the GP was hindered by feelings of vulnerability at the time of help-seeking. Moreover, primary health carers should pay particular attention to power dynamics in taking an expert role (Harrison, 2013) and actively seek the opinions of those males seeking help and listen to their concerns regarding their health and course of treatment.

Furthermore, several reasons were attributed to GPs' unhelpfulness, such as participants' male gender and a lack of ED knowledge among professionals, which has also emerged in the literature (Räisänen & Hunt, 2014). However, the short time allocated to GP consultations has been also reported to impact on the GP's ability to diagnose participants. Although research has suggested that GP engagement with patients (through listening and trying to understand patients) could have a higher impact on patients' satisfaction (Lemon, & Smith, 2014), there is also evidence that longer consultations are associated with person-centred care (Orto & Pereira Gray, 2016). Also, it has been reported that readily available materials such as a sheet containing information about EDs and how to refer patients could help increase males' agency in GP consultations.

Several other aspects were also reported to influence men's satisfaction with treatment, such as the importance of gender in ED treatment. Some participants found the gender of the therapist to be an important aspect in their treatment, similar to previous research (Kinnaird et al., 2019; Leichtman & Toman, 2017), with some reporting a preference for female therapists. They attributed such a preference to the female therapist's warmth as opposed to directness, which they associated with male therapists. However, others preferred direct therapists regardless of gender, and the warmth associated with female therapists was viewed as unhelpful. Others expected to prefer male therapists at the beginning of their treatment, but during the course of therapy they grew to value their skills and therapeutic modality, resulting in their gender becoming irrelevant.

Furthermore, for a minority of participants, the gender of the staff was relevant during treatment and one participant associated a preference for female staff and GPs to his gay sexuality, which led to him failing to bond with the male healthcare professionals due to the adoption of masculine ideals implied in their suggestions to 'man-up' or talk about non-shared topics of interest like football. Additionally, a lack of understanding from healthcare professionals was attributed to older age, as it was believed older professionals might hold rigid values in relation to aspects such as being gay.

Moreover, a preference for individual or group therapy also yielded mixed responses, as some participants expressed a preference for individual therapy as they felt isolated as the only male in the group, while others believed their issues as a male would not be addressed in a group setting dominated by females, which is line with the current literature (Thapliyal et al., 2017; Thapliyal et al., 2020). Some also reported that they perceived group therapy as more of a dating setting than a therapeutic one.

Regarding treatment strategies, those viewed as helpful were goal setting, increase in food knowledge (food portions and nutrition), integration of information and understanding their ED triggers, multidisciplinary team approach, and an option for remote sessions. Reported as unhelpful were an increase in food consumption, no initial perception of gain but a loss of symptoms, lack of therapist ED knowledge, change of therapists during treatment, and a perception of therapy as a form of dependency. A sense of humour was also reported to be a strategy that could be helpful if incorporated during treatment. However, it could also function as a way to avoid dealing with the issue (Siegel & Sawyer, 2020).

Additionally, self-implemented strategies such as avoiding weight-measuring, re-reading materials from a previous course of therapy, deleting social media, and using mindfulness apps were reported as helpful. Among treatment difficulties, an increase in food consumption, no perceived treatment benefits (only taking the AN way), lack of therapist knowledge, change of therapist, and wanting to cope alone were highlighted by participants.

Power in treatment was also a significant aspect for some participants in this study. This related to their lack of choice in the length of treatment, and varying treatment quality due to differences in funding according to geographical location or a ‘post code lottery’, although the latter was not directly related to the participants in the current study. Also, some received faster treatments due to initially seeking private help, but still faced long waiting times for NHS specialist help due to COVID-19. Furthermore, the choice between at home or inpatient treatment was also aided by parents that were able to provide full-time care.

These findings all indicate that participants in this study faced several issues regarding their treatment experience and recovery that were beyond their personal choice and reflected broader social contexts that included power relations associated with age, family, and economic means of borough, along with wider contexts affecting health-delivery such as the pandemic. Additionally, due to the latter, some males did not have a choice over treatment delivery, as services were delivered online. Even though remote or in person therapy delivery was not under participants’ control, online therapy still proved useful as a medium for treatment.

Among the recovery strategies, several participants reported wanting to improve as a crucial component of their recovery, which has also been highlighted by other studies (Lyons et al., 2019; Pettersen et al., 2016). Moreover, wanting to recover was associated with taking agency over the guidance received in treatment. However, some participants also reported that recovery would never be fully achieved, congruent with the experience of other males with EDs in the literature (Björk et al., 2012; Pettersen et al., 2016; Thapliyal et al., 2020).

The theme "steps for change" reflected a varied view of the helpful and unhelpful aspects associated with help-seeking, diagnosis, healthcare professionals, treatment, and recovery. These were associated with several characteristics of males and professionals and include agency, appearance, behaviour, vulnerability, knowledge, consultation length, gender, sexuality, group or individual therapy, treatment and self-implemented strategies, power in treatment rooted in wider social contexts, and agency in recovery.

This highlights the importance of personal meaning and individual preferences as well as the role of gender in treatment settings. Males with EDs wanting to recover crucially demonstrate the personal agency emphasised by critical realism, indicating that people are not merely at the mercy of external factors. However, these findings also demonstrate that agency is affected by wider contexts such as power dynamics, sociocultural norms associated with biological sex, age, residence location, social restrictions imposed by the pandemic, and the structure of health services.

Wider contexts such as healthcare settings, for example, need to provide a choice of treatments as recommended by NICE (2017). As discussed in the literature review, these consist of several different types of therapies for EDs depending on the client's presentation. They are based on a diverse range of strategies and aims, ranging from CBT to psychoanalytical approaches, which in turn can be based on very different philosophical paradigms.

For example, the CBT model assumes a model of a person and treatment parallel to programming information, in this case cognitions, when implementing ways to change behaviour. As such, it aims to reframe thoughts that are considered maladaptive (Willig, 2019). Moreover, even though CBT for EDs addresses aspects such as self-esteem, body image, and individual processes associated with ED maintenance (NICE, 2017) it places a strong emphasis on the individual's role. The findings of this study also highlight deeper aspects of the reality that seems to be at play with ED symptoms in males, such as the role of gender norms. From a clinical perspective, this implies that a deeper exploration of meaning would be necessary to understand males' experiences of their ED symptoms, as these seem to be strongly associated with wider sociocultural contexts. Moreover, in line with treatment guidelines, several aspects associated with the male gender should be considered when treating boys and men (APA, 2018).

In the current study, participants also reported a preference for a range of a therapeutic approaches and therapists' characteristics, ranging from more focus on behaviour to greater emphasis on establishing a therapeutic relationship, or a preference for a balance between both styles. This demonstrates that there should be a focus on individual meaning and preference when treating males with EDs (while still accounting for the necessity to focus on physical restoration first if that is posing a risk, such as restoring weight).

Gender-transformative interventions are an example of targeting wider social structures associated with males' health. Fleming (2014) suggested that health promotions targeting males should be gender-transformative by challenging gender norms, and strategies should focus on engaging males (by providing a safe space and bring them together) in talking about and questioning the meaning of their gender in relation to their health (i.e., help seeking, engaging in harmful activities). These could be delivered in several ways, such as through media and during therapy.

Thus, health promotions for males should consider multiple aspects associated with causes of distress at psychological, biological, and social levels (Pilgrim, 2014), and ED treatment and interventions should be viewed through the lens of gender, the latter defined by Messner (1997) as highlighting the role of gender in social processes to question systemic inequalities between men and women. Thus, it is essential to question assumptions about gender and explore the influence of these on wider social structures.

Moreover, participants reported several triggers they associated with their ED symptoms. For example, similar to Thapliyal et al.'s (2020) study, the presence of family members was associated with the occurrence of fewer ED behaviours for some participants, which suggests the presence of family could function as a protective factor or that males supressed ED behaviours in their presence. However, in the current study, a higher occurrence of ED behaviours in the absence of close ones, such as a fiancé, could be also due to sadness resulting from the break-up and other stressors associated with moving out of the family house and starting a university course. Therefore, it is unclear which roles the presence and absence of family played in the occurrence of participants' ED behaviours.

Regarding differences according to ED subtype, participants diagnosed with AN and BED both described their EDs as a way to cope. However, coping seemed to manifest as behaviours aimed at exercising and dieting for AN and eating for BED, which is not surprising given the characteristics specific to each ED and literature suggesting ED behaviours help sufferers cope with negative moods (Fairburn, Cooper, & Shafran, 2003).

Moreover, participants with BN and AN reported growing up with an excess of food. One participant with BN associated this with a subsequent lack of ability to identify hunger satiation, while the participant with AN associated it with the demonstration of love by their family. Participants with BN, AN and BED all reported judgments from others regarding their bodies as driving weight-loss and body image improvement behaviours, emphasising the role of the body as a social instrument.

Therefore, several participants emphasised the meaning of the body in relation to their ED symptoms, exemplifying the way in which dieting and exercising were secondary to how they experienced their bodies in relation to themselves and others, and how such experiences were permeated by cultural and social values of beauty and gender. This has also been reported in previous literature (Delderfield, 2018).

Moreover, most participants reported body dissatisfaction as being associated with their EDs, particularly dissatisfaction with excess of weight, which replicates several earlier studies (Boon et al., 2017; Leichtman & Toman, 2017; Wallin et al., 2014). Also, the males in this study did not report wanting to have a muscular body. Most reported aiming for weight-loss and discussed the role of their bodies in multiple contexts, such as using them to bring a sense of achievement, love from others, hide sexuality, and delay growing-up, all of which is congruent with previous literature (Delderfield, 2018; Robinson et al., 2013).

Additionally, males also emphasised the impact of family on eating practices, including those associated with their EDs, such as associating food with love and consuming large amounts of food. This further indicates that the experience of the body and EDs were strongly influenced by social and cultural values and expectations.

Similar to previous research (Thapliyal et al., 2020), some participants reported that their experience was not taken seriously as straight males with EDs, due to the association of EDs with females and gay males. Furthermore, gay sexuality was mentioned by some participants as relevant to their experiences with EDs, as they believed ED was more likely to occur in gay males than straight males. Such a belief is also reflected in the literature, possibly due to a high emphasis on body image (Boon et al., 2017; Bosley, 2011; Jones & Morgan, 2010). Also, an ED was reported as a way of avoiding dealing with sexuality, which is similar to Boon and colleagues' (2017) study, where participants reported that excess weight and concerns with sexuality were associated with the onset of their ED.

Another key finding of this study was the influence of COVID-19 on participants' EDs and recovery. Due to the period in which this study was conducted, some participants reported that the imposed lockdown restrictions acted as a trigger for their EDs, as some males initiated exercising and diet routines due to the resulting free time, while others began binge-eating due to the lack of activities and restricted social contact. Also, restrictions such as closing down gyms were reported as triggering doubts about the maintenance of behaviours and routines aimed at maintaining recovery.

These are congruent with the emerging literature suggesting a negative impact of the COVID-19 pandemic on people with EDs (Clark Bryan et al., 2020; Branley-Bell & Talbot, 2021; Brown et al., 2021; Hunter & Gibson, 2021; McCombie et al., 2020;). This is attributed to the resulting social isolation, changes in routine, restricted access to food and healthcare. and higher levels of anxiety (Linardon et al., 2021; Miniati et al, 2021; Rodgers et al. 2020). Nevertheless, in the literature some people reported the lockdown as being helpful for recovery due to increased self-efficacy (Brown et al., 2021). However, in the present study, all experiences associated with the lockdown were mostly negative, and positive aspects associated with lockdown were associated with ED development (i.e., starting exercising and dieting; initially seen as healthy and having a bonding function via video calls).

Also, there have been suggestions in the literature that the COVID-19 lockdown restrictions affected females and young people more than males (Robertson et al., 2021). Yet to date, and as far as we are aware, there are no published studies exclusively focusing on the experiences of males with EDs. Therefore, the present findings are novel in describing males' experiences of their EDs and recovery in the context of the COVID-19 pandemic, and as such make a useful contribution to the current literature.

4.2.4 Theme 4. EDs are not part of men’s reality

Furthermore, several participants did not experience EDs as part of their reality due to the perception of a lack of ED information about men. This was attributed to the general focus on ED in females, the stigma associated with mental health in males as a result of adhering to ideals of masculinity (i.e., the expectancy that males should be strong) and less importance given to EDs compared with other mental disorders such as depression.

Additionally, the experience of ED as not part of men’s reality was represented by reports of ED as not being a male subject, which was associated with shame and the perceptions both of themselves and others. Males attributed the shame of sharing to the stigma associated with mental health, being perceived as weak, and closeness to the person.

Participants also reported several other barriers to sharing with participants, such as fear of other people’s changes of perception, lack of understanding among those who do not have the lived experience of EDs, not wanting an ED to define identity after recovery, beliefs that talking about an ED would increase the problem, the feeling that it was a boring topic, and body talk as being a female or gay subject. Some participants also mentioned that they did not share because ED was not visible in the body or not having inpatient treatment as they thought they would not be believed by others. This suggests that for some males, not having a physical manifestation of their distress acted as a barrier to disclosing their EDs. Additionally, prominent among the barriers to sharing, particularly with regard to family, were existing difficulties, lack of impartiality, and cultural background or generational differences that resulted in a lack of belief about the existence of mental health.

Additionally, feeling abnormal regarding body parts, such as the chest and being gay, was reported as a barrier to sharing by some males. Dissatisfaction specifically with chests, due to the perception of it possessing a female characteristic (woman's breasts) or not being slim and strong enough, resulted in experiencing the body as abnormal and a subsequent wish to change it. This builds on the literature suggesting that males are concerned with specific body parts, such as muscular chest and arms (Dakanalis et al., 2012), emphasising that expectations of body shape according to gender can lead to body dissatisfaction in males, psychological distress, and ED risk. Additionally, this finding also highlights that such bodily perceptions might act as a deterrent to sharing experiences with others. Experience of abnormality was also attributed to a male with an ED in conjunction with being gay, which consequently was found to act as a barrier to sharing ED experiences with other straight men.

Therefore, due to all these barriers and the formulation of EDs as a topic that belongs exclusively to females or gay males (due to the association with feminised stereotypes), some participants found it easier to share with females or gay males. Similarly, males in Siegel and Sawyer's (202) study found it easier to talk about their EDs with female work colleagues rather than male colleagues. However, the authors suggested this was due to participants' awareness of the higher ED stigma held by males. Conversely, in the current study, participants' difficulty sharing with other males was attributed to associating EDs with topics they perceived as belonging to females, such as topics relating to body, diet, and exercise. Thus, it did not form part of their reality. Therefore, it seems that the expectation of a shared interest among groups (e.g., gay men and women) seems to be a facilitator for participants to share with these specific populations but not with other men; their perception that other men do not share the same interest or understanding of this topic therefore acts as a barrier to sharing with other men.

On the other hand, participants reported several facilitators of sharing, such as the normalisation of other males sharing their experiences with EDs, especially if displayed in the media. However, most participants felt there was not enough males with ED presented in the media, echoing previous qualitative research (Robinson et al., 2013). However, some highlighted the recent spotlight on some males talking about their EDs on the media; most participants mentioning a television documentary released in 2020, featuring Fred Flintoff, who is an English television presenter and former cricketer, openly talking about his experience with disordered eating and exercising. Most participants reported relating to his experience and felt that it helped them to feel less isolated and reduced the stigma associated with ED in males.

Nevertheless, some participants expressed surprise that EDs could happen to someone as outgoing and strong as Fred, reflecting participants' strong adherence to beliefs associating ED with female stereotypes, as discussed previously. Others perceived Fred's straight sexuality as helpful in disseminating information about EDs in straight males, compared with other famous males that were gay or perceived as not being taken seriously, such as John Prescott. This is congruent with the suggestion that the media might perpetuate the stigma associated with males with EDs by linking them to females or using flippant language (MacLean et al., 2015).

Participants reported several sharing strategies which ultimately led to a reduction in feelings of isolation, higher acceptance of themselves., and help-seeking. Some also expressed a preference for taking the lead when sharing with friends, sending text messages, and feeling they were in a safe space and were not going to be judged. Sharing was also reported to lead to the acceptance of males in previous studies (Björk et al., 2012).

Throughout this theme, it is evident that for the males in this study, EDs assume a role outside their reality due to the absence of certain factors: a lack of information, lack of others having a lived experience, lack of visibility in the body, lack of relevance within a male context, and lack of belief in ED as a disorder, all of which render ED a non-existent characteristic in males' experiences. This makes it difficult for them to share with others, as how can you share something that does not exist? Thus, EDs in males are not talked about and males who happen to experience such a reality do not talk about it with other males as it is assumed they are not part of their reality. Moreover, what existed in this theme was the visibility of women's breast and EDs as a female subject, further distancing EDs from the reality of males.

However, it was surprising that most participants referred to Fred Flintoff's documentary and reported that it helped to reduce their isolation as men and also believed it would help other males. In this sense, Fred Flintoff's documentary seems to represent Bhaskar's real layer of reality for some participants, as his embodiment of masculine ideals in addition to associated symptoms of EDs such as excessive exercising, constant preoccupation and dissatisfaction with body weight and food amounts, and purging, clearly displayed on television, helped some participants to recognise and validate (empirical layer) their actual reality (ED symptoms) as men. This suggests that males with a lived experience of ED symptoms can help raise awareness and normalise EDs in males, making the non-existent an existing reality for males.

4.3 Strengths and Limitations

4.3.1 Limitations

Most participants in this study were White and from the UK; thus, the experiences reported here might not be representative of males from other ethnic backgrounds or Eastern cultures. Nevertheless, out of the eleven participants, four were from diverse backgrounds. However, all experienced symptom onset and diagnosis in the UK. Yet their reports contained cultural references to family and food practices that coloured their ED experiences, hence providing richness in their narratives. Despite this, conclusions should be interpreted in the context of participants' Western sociocultural backgrounds and the small sample size.

Furthermore, sexuality was not explored, even though two participants reported as gay and for both participants their sexuality impacted their experiences and perception of EDs. Investigating EDs in males from a diverse sexuality remains underexplored, but is important given the evidence suggesting the high risk of EDs among this population (Bosley, 2011). Another issue is that the mean age of participants was around 29 years, ranging from 19 to 45 years. Thus, the experiences of EDs in young or older males were not explored. This could have been helpful in providing insight into their specific experiences, as onset of EDs is suggested to start at young ages (Gorrell & Murray, 2019), and there are few studies examining older males (Murray et al., 2017). A greater breadth of age would have perhaps illuminated different phases of the disorder, providing an important historical context and suggesting potential changes in services and also gender roles (which could reflect different norms of masculinity and how these might influence experiences with EDs).

Additionally, comparison between treatment type and length among participants was not explored, nor was there a detailed comparison between ED subtypes and the themes reported. This could have been useful for exploring in depth experiences according to ED symptoms and also potential differences in the body (AN more associated with low weight and BED with higher weight), and how the effect of EDs on body appearance might affect the experience of EDs in relation to oneself, others, treatment, and recovery.

All interviews took place via online video due to the pandemic, which may have limited the participation of males that did not have access to internet and instruments (i.e., mobile or computer), thus excluding less affluent participants and reducing the representativeness of the sample to more affluent males. Also, the males that took part were those that wished to share their experiences with EDs, and as such may have presented a more negative account of their journeys with EDs. Nevertheless, the recruitment process took a long time, possibly reflecting males' unwillingness to share personal details, or not being used to share emotional content.

4.3.2 Strengths

This study included participants with a diagnosis of all main EDs (AN, BN, and BED) which is rare in the current ED literature on males. Also, despite the White and straight majority, this study also included gay participants and participants from a diverse cultural background (Latino, Eastern, and African family background), thereby enriching the findings.

In addition, this study highlighted the impact of the COVID-19 pandemic restrictions on the experience of some participants in accessing and engaging in treatment and maintaining recovery. This a novel finding that contributes to the current ED literature in males.

Another strength was the research paradigm which resulted in the production of more insight into males with EDs and offered a platform for them to voice their experiences, as the reality of their journeys with EDs is often marginalised and not taken into consideration within the wider social sphere.

4.4 Areas for Further Research

For the reasons discussed earlier, there is a need for more research on males from minority backgrounds, including non-White males and those from diverse age ranges, and ethnic and sexual backgrounds. Also, due to the suggested impact of gender roles on males' experiences of EDs, future research could focus on the cultural and social influences of gender roles and EDs, as proposed by Darmstadt et al. (2019), and how these might play out in treatment in relation to healthcare professionals, ED materials, treatment, and treatment settings.

Moreover, several males in this study spoke about the benefits of knowing other males with EDs, which included reducing the isolation associated with the ED experience. Thus, future research could include males with EDs in their design, such as adopting focus groups or interviewing methods, which could help generate additional data due to the reported lack of available safe spaces to encounter other males with similar experiences of EDs. This would help to validate their experiences, reduce their isolation, and increase their sense of agency and power.

Additionally, given the marginalisation of this population from research, EDs in general, and this research paradigm, future research could examine males' experiences utilising a GT method of analysis. This would render more evident the potential mechanisms at play in reducing males' agency in relation to EDs and generate theory that could be put into practice and researched further. This could aid clinical practice and generate implications and directions that better cater for males' needs.

4.5 Post-Research Reflexivity

4.5.1 Epistemological

The critical realist stance adopted in this study considers that participants' reality can only be accessed through their accounts of it. Moreover, such accounts were subject to my own perceptions of what was said. Therefore, I acknowledge that the participants' reality of ED experiences presented in this study could have been analysed differently by another researcher. Also, as a counselling psychologist in training, I have positioned myself within the humanistic frame of this field (Strawbridge & Woolfe, 2010) and considered participants' individuality in terms of their views of the world, which is in line with the critical realist position of considering idiosyncratic meanings ascribed to reality (Willig, 2013).

4.5.2 Personal

Prior to interviewing, I was aware of my outsider position in relation to participants (Oguntokun, 1998) due to my female gender, lack of a lived experience of ED symptoms, and my role as a researcher, and how these could influence the research and my relationship with participants, which could ultimately affect the material they chose to disclose. Thus, my predominantly ‘outsider’ position in this research helped me to avoid making assumptions about participants’ experiences; consequently, I remained curious and open to their narratives. However, I was not able to completely remove the knowledge acquired from the literature review during the interviews, particularly given that the interview questions were based on such literature; thus, its influence has to be recognised.

Nevertheless, I strived to remain as close as possible to their experience and pay particular attention to occasions when my prior knowledge could be interfering, so that I could acknowledge this and refocus on participants’ experiences. For example, this meant becoming aware of when I asked leading questions such as ‘have you ever felt stigmatised because you are a man?’, which was based on the literature review, and then making a conscious effort to remain open and avoid asking leading questions.

Moreover, at the end of each interview, I asked participants how they felt and how they found the process. Yet I have to acknowledge that I did not openly ask how they felt being interviewed by a female, despite my prior awareness and reflection on my female gender. This is notable because it mimicked the experience of several participants during their treatment, where the gender of professionals remained unacknowledged and unquestioned.

Thus, gender at some level in this research also seemed to assume a characteristic of invisibility in the process of relating to others, despite its obvious features (mostly demonstrated by the physical body in the adoption of feminine or masculine gender norms). Upon reflection, clearly asking participants how they felt about my gender could have elicited more knowledge about their experiences disclosing what it was like to have ED symptoms with a female. Nevertheless, it is also important to note that all participants felt positive about their participation in the research and felt valued in having been given a platform to share their experiences. For one participant, it was the first time they had spoken to someone apart from their GP, while others noted that the process was helpful and they felt better for having shared their experience with the researcher.

I also paid careful attention during the analysis to ensure that the data reflected participants' accounts as closely as possible. Nevertheless, despite my intention to be objective in analysing and reporting the findings, so that they reflected participants' experiences and the meanings ascribed to them, the entire organisation of the data was permeated by my interpretation of their experiences. This is in accordance with critical realism, which holds that reality cannot be accessed directly, but only through my interpretation.

Nevertheless, the process of familiarisation with the data allowed me to become attuned with participants' tone of voice (during interview and transcription), and the repetition of words and descriptions in order to guide my bottom-up analysis. I therefore purposefully strove to approach the data during the coding with as few assumptions as possible.

4.5.3 Methodological

During all the interviews I recall being extremely aware of my role as interviewer and not as a therapist. This was very challenging at times due to my usual position as a trainee counselling psychologist exploring deep and personal experiences. For this reason, several times I found myself taking care not to be intrusive when asking follow-up questions, I was concerned this might have led to exploring the issue in a more intimate way, which I associate with therapy sessions. This sometimes led to disappointment while transcribing the interviews, as it was then that I most realised I had missed opportunities to explore some of the participants' meanings at a deeper level There were a few occasions on which I could have gained more insight into their experiences by asking more questions and consequently could have generated even richer data. Nevertheless, I also acknowledge participants' agency in deciding what they chose to share with me at the time and what they regarded as relevant to report. Thus, I believe that despite such shortcomings, the interviews still produced very rich data on participants' experiences.

Also, several participants mentioned during the interview the importance of raising awareness among males with EDs and felt hopeful that this research could help support. Therefore, especially during the analysis, I felt an immense sense of pressure and obligation to portray males' experiences as closely as possible to their meaning and at times I struggled to group the coding into themes, as I wanted to portray their experiences as they had reported them.

For this reason, and due to the enormous amount of data collected during the interviews that I needed to process, keeping a reflective diary helped me to reflect on my own feelings and approach to the data. It made me realise that it was impossible to keep and report all the idiosyncratic meanings and experiences participants shared with me. Instead, I had to accept that the themes constituted representation of the meaning of the whole group, as per my research aim, although I still tried to remain as close as possible to their individual meanings while organising and reporting the data.

Consequently, I found myself regrouping and renaming the themes in order to stay close to participants' accounts rather than being guided by previous literature or theory. Also, during the analysis, a metaphor kept coming to mind in relation to how I was experiencing the data: the vast amount and complexity of the information collected made me feel as if I had 'ingested' eleven very large 'meals' and I was finding it very hard to process all the 'food'. This at times let me feel overwhelmed, so it was helpful to take breaks and take time to digest one 'meal' (or interview) and also to normalise the lengthy time that it was taking, so as to do justice to participants' experiences. Nevertheless, sometimes I found myself in the process of 'binge-eating' the data and I 'restricted eating' by refraining from analysing it, which led to feelings of guilt, which was then followed by a new cycle of 'binge'. Such breaks and reflection allowed me to distance myself from the data, physically and mentally, which enabled me to approach it again with new perspectives and viewpoints, as if I was no longer 'full' and ready for another 'meal'.

4.6 Research Evaluation

The quality of the current study was established by rigorously following the TA steps proposed by Braun and Clarke (2006) and by following Morrow's (2005) criteria of post-positivist research evaluation of credibility, transferability, dependability and confirmability, as described in the methodology chapter.

The significant influence of the researcher in the current study is recognised. Firstly, the data could have been organised, presented, and discussed in several ways, different from the ones presented here, due to the complexity and interconnectedness of participants' experiences and my own influence in analysing and organising the data. Secondly, other research might have elicited different responses to the questions during the interviews by asking different main questions and follow-up questions, thus eliciting different data.

However, despite the findings reflecting the experiences of a specific set of eleven males with EDs and the influence of the current researcher on the overall study, they also reflect important aspects of their experiences and offer valuable insights for current ED research and health professionals concerned with increasing the wellbeing of males experiencing ED symptoms.

4.7 Clinical implications and relevance to Counselling Psychology

The current study investigated a population that has been historically marginalised from ED research, clinical practice, and wider sociocultural contexts, and provided a platform for males with EDs to share their experiences. Most participants reported taking part in this study to raise awareness about ED in males in the hope of helping other males going through similar experiences.

Hopefully, the findings from this study will help to equip psychologists and other healthcare professionals with information unique to males with EDs. This will assist in improving services and treatment that cater for the specific needs of this population and which are currently lacking (Copperman 2000), as well as generating more research in this area. The current findings suggest several areas that could be helpful in improving the experiences of males with EDs, such as increasing awareness through higher visibility of males in ED materials, and open discussion of the role of gender and gender socialisation in treatment settings.

Additionally, these findings brought to the fore wider systemic cultural and social contexts that influence males with EDs, due to EDs strong association with the female gender and also the personal meaning of EDs manifested in the body as part of relating to oneself and others. Moreover, a concern with changing social contexts and promoting agency are crucial tenets of promoting justice (Coghlan & Brydon-Miller, 2014).

Therefore, as counselling psychologists, it is paramount to focus on social justice by promoting awareness of this systemic marginalisation of males with EDs and to integrate this into research and clinical practice (Buki, 2014). It is also important to promote changes in broader aspects of health organisations in relation to how they cater for males with EDs. It is hoped that clinicians will become more active in challenging systemic structures that restrain males' agency in relation to EDs and enhance their practices by questioning and reflecting with their clients on how gender and gender norms could be negatively affecting males experiencing ED symptoms.

4.8 Conclusion

This study aimed to understand males' experiences associated with their EDs in depth and provided a rich account that can helpfully equip clinicians and other males with EDs with more information on some of the unique challenges they face.
Several findings from this study echoes those of studies published ten years ago. It could be argued that despite some of the participants in the current study receiving a diagnosis more than ten years ago, which could explain some of the similar findings, four males in this study were diagnosed in the last three years, yet their experiences are still strongly similar to those of other males. This indicates that much remains unchanged regarding information about EDs and treatment, which seems to remain female centric and does not cater to the specific needs of males.

Most of the findings in this study were associated implicitly or explicitly with gender norms pertaining to masculinity that affected how males experienced their EDs and mostly had a negative impact. This indicates that males' experiences of EDs are systematically rooted in societal and cultural values that are heavily influenced by gender stereotypes, where negative attributes are mostly associated with the female gender. Questions have already been raised in research as to why males perceive so negatively something that has a feminine connotation (Delderfield, 2018).

Such values indirectly demonstrate the influence of mechanisms such as privilege and the historical social and economic power of men over women and other minorities, which in this case is not only prejudicial to females but also to males. Although feminist movements have resulted in shifts in power relations between men and women, hegemonic masculinities remain dominant. This results in negative consequences, including for males, as adherence to masculine ideals of control, dominance, and strength aimed at achieving social power and avoiding social exclusion can lead to males engaging in risky activities which can negatively impact their well-being (Messner, 1997).

Mesnner (1997) argued that men's separation from women (what it means to be a woman or a man) in order to feel empowered needs to be challenged and that is necessary for males to discuss their fears and issues among themselves and also with women. This will help to disrupt the maintenance of power over women and, consequently, the maintenance of unhelpful adoption of masculine norms. Thus, within an ED context, gender ideals should be challenged to improve gender equality in ED research and in clinical contexts.

Moreover, due to gender norms being influenced by several sociocultural factors, such as economic influences, political structures, socialisation, education, family, institutions, and policies, it is necessary to address these underlying mechanisms of reality and, according to critical realism, this is achieved through human agency. It begins with reflecting about such issues and making choices to transform them and, in turn, be transformed by them (Houston, 2001; Pilgrim, 2020). It is hoped that these findings can provide a call for action for more gender equality within the ED field by addressing and targeting wider societal and cultural contexts. This will serve to improve males' agency in relation to EDs and reduce the alienation of EDs from the experiences of males.

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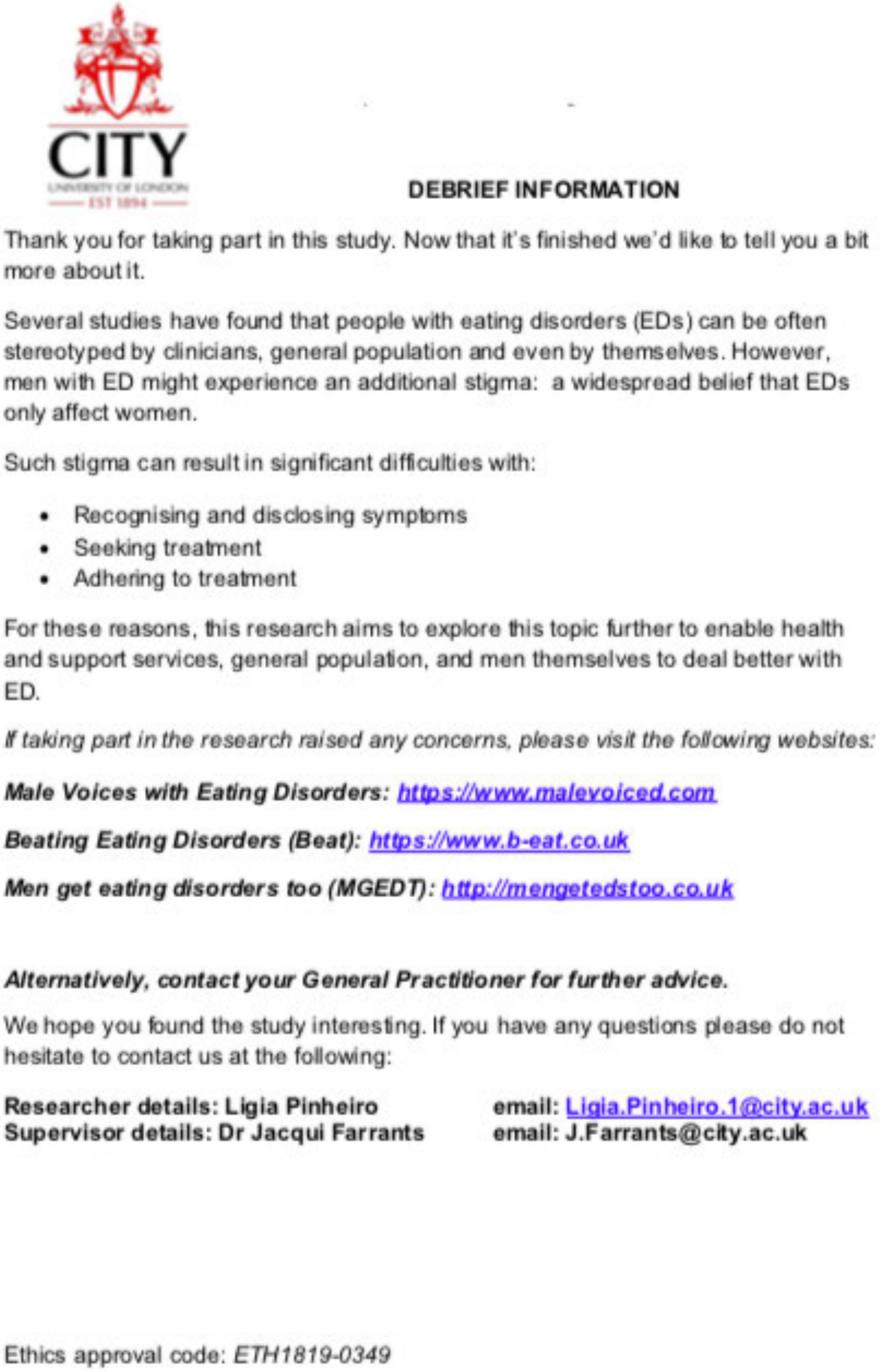
APPENDIX A: Debrief information



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DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

Several studies have found that people with eating disorders (EDs) can be often stereotyped by clinicians, general population and even by themselves. However, men with ED might experience an additional stigma: a widespread belief that EDs only affect women.

Such stigma can result in significant difficulties with:

- Recognising and disclosing symptoms
- Seeking treatment
- Adhering to treatment

For these reasons, this research aims to explore this topic further to enable health and support services, general population, and men themselves to deal better with ED.

If taking part in the research raised any concerns, please visit the following websites:

Male Voices with Eating Disorders: ***https://www.malevoiced.com***

Beating Eating Disorders (Beat): ***https://www.b-eat.co.uk***

Men get eating disorders too (MGEDT): ***http://mengetedstoo.co.uk***

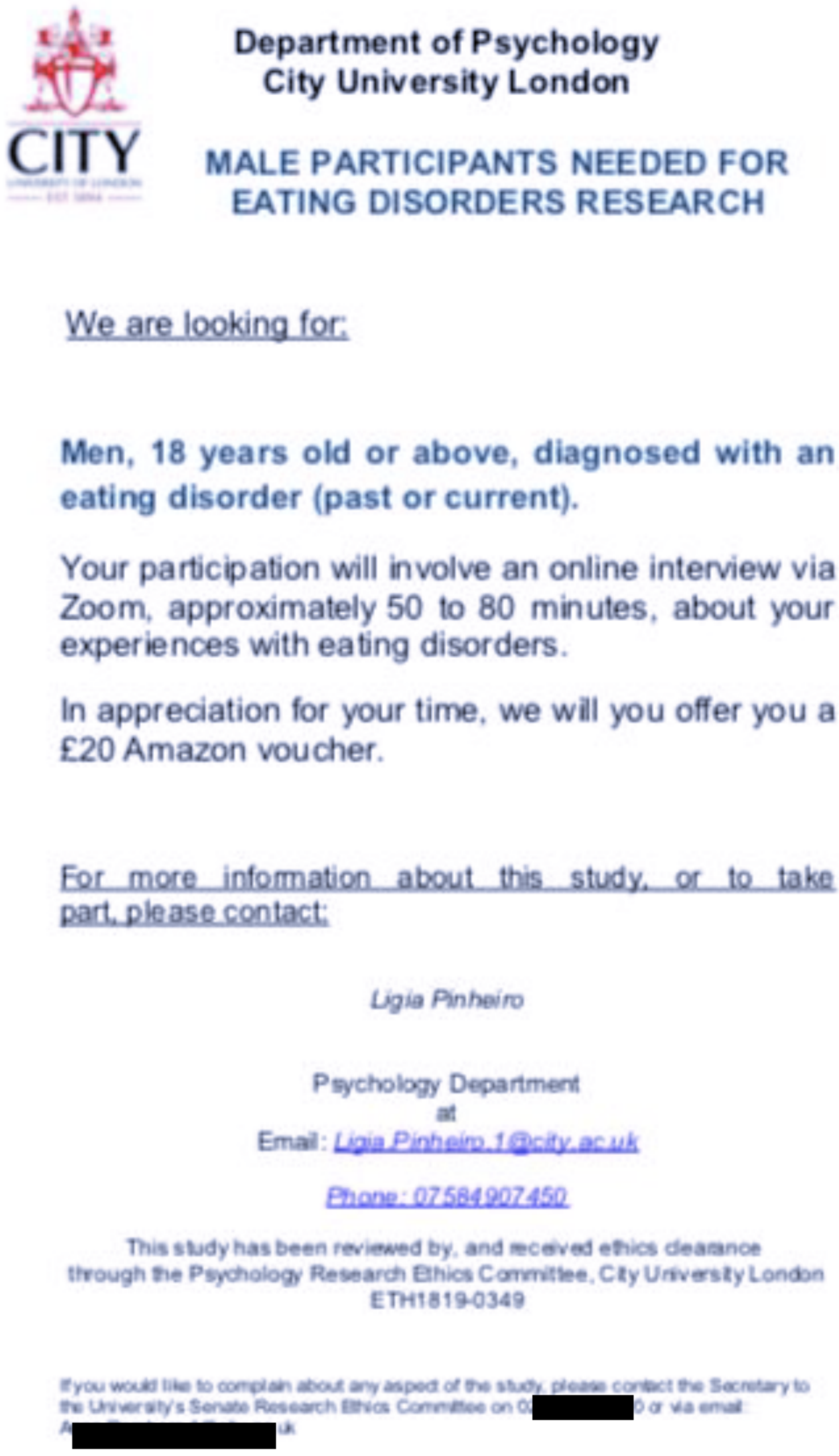
Alternatively, contact your General Practitioner for further advice.

We hope you found the study interesting. If you have any questions please do not hesitate to contact us at the following:

Researcher details: Ligia Pinheiro **email: Ligia.Pinheiro.1@city.ac.uk**
Supervisor details: Dr Jacqui Farrants **email: J.Farrants@city.ac.uk**

Ethics approval code: *ETH1819-0349*

APPENDIX B: Recruitment Advert



Department of Psychology
City University London

MALE PARTICIPANTS NEEDED FOR EATING DISORDERS RESEARCH

We are looking for:

Men, 18 years old or above, diagnosed with an eating disorder (past or current).

Your participation will involve an online interview via Zoom, approximately 50 to 80 minutes, about your experiences with eating disorders.

In appreciation for your time, we will you offer you a £20 Amazon voucher.

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

Ligia Pinheiro

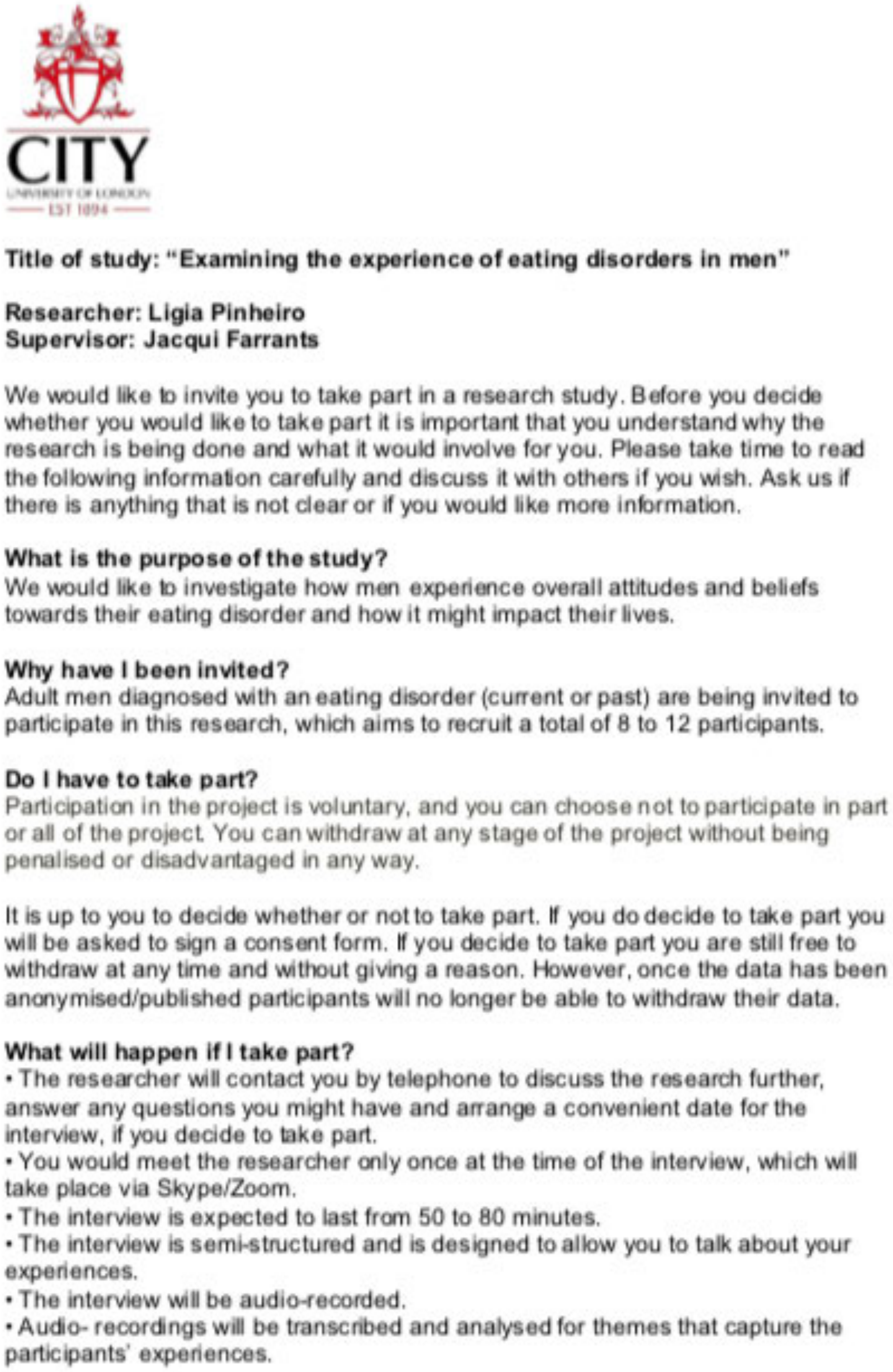
Psychology Department
at
Email: *Ligia.Pinheiro.1@city.ac.uk*

Phone: 07584907450

This study has been reviewed by, and received ethics clearance through the Psychology Research Ethics Committee, City University London
ETH1819-0349

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 0[redacted]0 or via email: A[redacted]uk

APPENDIX C: Participant Information sheet



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Title of study: "Examining the experience of eating disorders in men"

Researcher: Ligia Pinheiro
Supervisor: Jacqui Farrants

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?
We would like to investigate how men experience overall attitudes and beliefs towards their eating disorder and how it might impact their lives.

Why have I been invited?
Adult men diagnosed with an eating disorder (current or past) are being invited to participate in this research, which aims to recruit a total of 8 to 12 participants.

Do I have to take part?
Participation in the project is voluntary, and you can choose not to participate in part or all of the project. You can withdraw at any stage of the project without being penalised or disadvantaged in any way.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. However, once the data has been anonymised/published participants will no longer be able to withdraw their data.

What will happen if I take part?
- The researcher will contact you by telephone to discuss the research further, answer any questions you might have and arrange a convenient date for the interview, if you decide to take part.
- You would meet the researcher only once at the time of the interview, which will take place via Skype/Zoom.
- The interview is expected to last from 50 to 80 minutes.
- The interview is semi-structured and is designed to allow you to talk about your experiences.
- The interview will be audio-recorded.
- Audio- recordings will be transcribed and analysed for themes that capture the participants' experiences.

Expenses and Payments

- You will be offered a £20 Amazon voucher.

What do I have to do?

The interview is designed to capture your experience with eating disorders, so there are no right or wrong answers and you are expected to answer according to your own views.

What are the possible disadvantages and risks of taking part?

There are no expected risks or disadvantages of taking part.

But, if you feel distressed during the interview, you can choose if you would like to pause or to end the interview, and then we can talk about the possibilities available, such as seek further help from eating disorders organisations or your General Practitioner.

What are the possible benefits of taking part?

Findings from this study could help to design strategies to improve eating disorder services and to generate awareness aimed at improving the wellbeing of men with eating disorders.

Also, talking about it can be beneficial because you can express your own views about it and contribute to research in this area.

Will my taking part in the study be kept confidential?

- Only the researcher will have access to the information before data anonymisation and the researcher's supervisor might have access to the data after anonymisation.
- Audio recordings will be transferred to a password-protected folder, and then transcription will ensure anonymised data.
- All information will be kept safe, secure and anonymous and only the researcher and the researcher's supervisor will have access to it.
- No information will be shared with anyone else.
- All information will be destroyed after 10 years. But if the project is abandoned before completion all data and stored information will be destroyed at such time.
- Confidentiality would only be breached if the researcher becomes concerned that you plan to harm yourself or others.

What should I do if I want to take part?

Please contact the researcher by the email address or telephone number provided at the end on this sheet.

What will happen to the results of the research study?

The results of this study will be part of a doctoral thesis, and potentially published in a scientific journal. All information provided will be anonymous, so your information will be not identifiable.

If you would like to receive a copy of the results, you can make a request by emailing the researcher: Ligia.Pinheiro.1@city.ac.uk

What will happen if I don't want to carry on with the study?
If you change your mind, you can withdraw at any time during the study, without providing explanation or being penalised.

You also have the right to withdraw your data from the study, without providing explanation or being penalised, up to three months after the interview has been completed.

Who has reviewed the study?
This study has been approved by City, University of London Psychology Research Ethics Committee

Further information and contact details

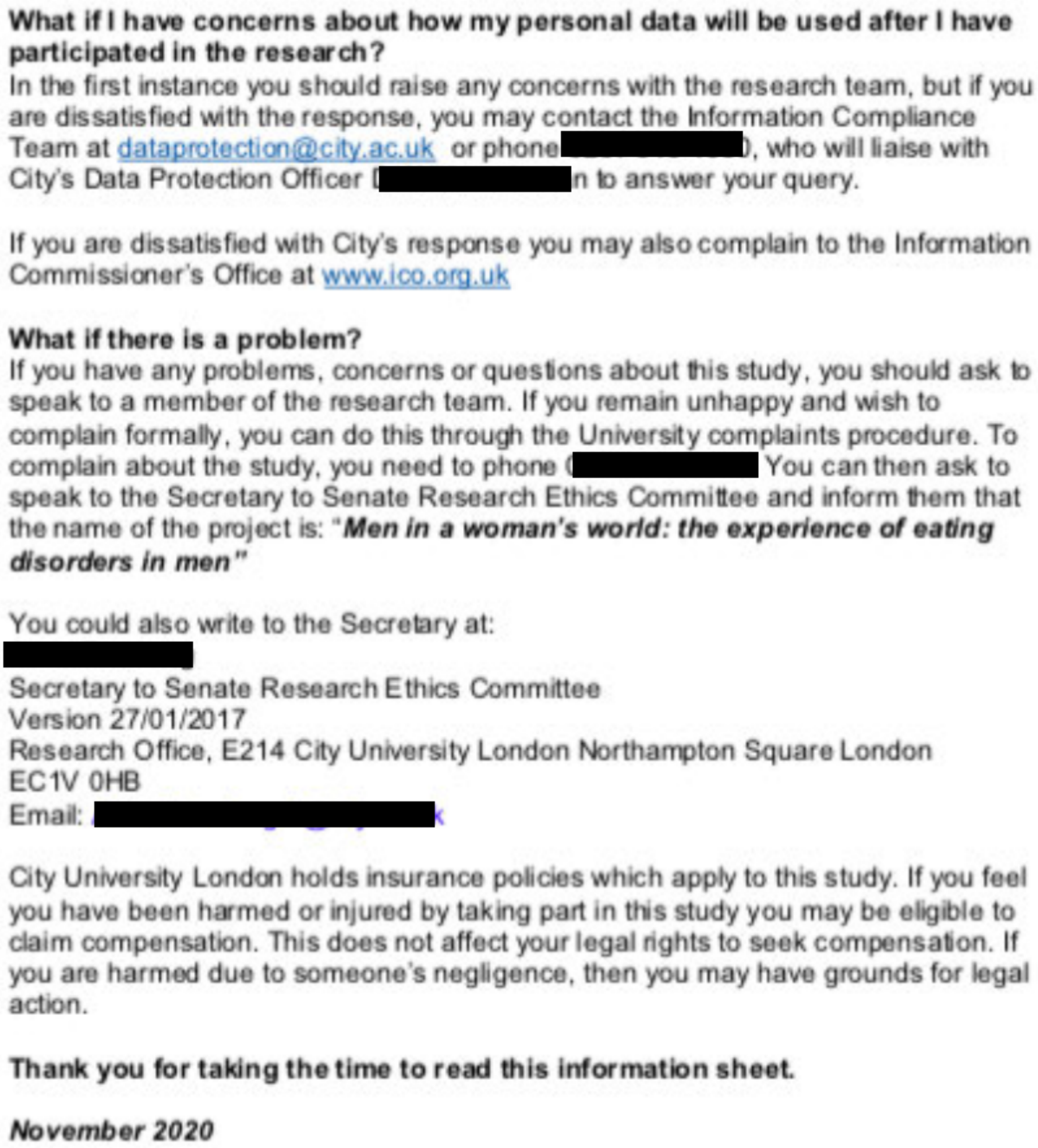
Researcher:
Ligia Pinheiro
Telephone: 07584907450
Email: Ligia.Pinheiro.1@city.ac.uk

Research Supervisor:
Dr Jacqui Farrants
Consultant Psychologist
Psychology Department
City, University of London
Northampton Square
London EC1V 0HB
020 7040 0172

Data Protection Privacy Notice: What are my rights under the data protection legislation?

City, University of London is the data controller for the personal data collected for this research project. Your personal data will be processed for the purposes outlined in this notice. The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City's Research Ethics Committees.

For more information, please visit www.city.ac.uk/about/city-information/legal



What if I have concerns about how my personal data will be used after I have participated in the research?
In the first instance you should raise any concerns with the research team, but if you are dissatisfied with the response, you may contact the Information Compliance Team at dataprotection@city.ac.uk or phone [redacted], who will liaise with City's Data Protection Officer [redacted] to answer your query.

If you are dissatisfied with City's response you may also complain to the Information Commissioner's Office at www.ico.org.uk

What if there is a problem?
If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone [redacted] You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: "***Men in a woman's world: the experience of eating disorders in men***"

You could also write to the Secretary at:
[redacted]
Secretary to Senate Research Ethics Committee
Version 27/01/2017
Research Office, E214 City University London Northampton Square London
EC1V 0HB
Email: [redacted]

City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Thank you for taking the time to read this information sheet.

November 2020

APPENDIX D: Interview Schedule

Warm-up question

Thank you for taking the time today. What led you to participate in this study?

1. Beliefs and attitudes associated with Diagnosis /ED Causes

1.1 Can you please tell what was your experience realising you had an ED?

Follow-up questions:

- What were/are the symptoms? Did you associate your symptoms to something else?
- What information you had available? Did you relate to it? How?

1.2 What was your experience with the process of being diagnosed?

Follow-up questions:

- Were you familiar with EDs before your diagnosis?
- Did the measures used: questionnaires, questions, addressed your symptoms?

2. Beliefs and attitudes associated with treatment

2.1 What was/has been your experience with treatment and health professional so far?

2.2 *How did you feel about this treatment experience?*

Follow-up questions:

- What treatment you received? How was it? Was it group/individual?
- Was it helpful/unhelpful?
- Could anything be improved?
- Was there any difference between treatments offered to females?
- What was your experience with healthcare professionals? Were thy helpful? Warm?
- How did you see them? How did they act towards you?
- Were there any changes in their attitudes during the course of diagnosis or treatment or post-treatment?
- Have you accessed health services before with something unrelated to the ED?
- How that experience compares with diagnosing/treating an ED?

- Was it different? How?
- During the diagnosis and treatment process, have you ever felt stigmatised/ treated unfairly because you are man?

3. **EDs beliefs and attitudes and their impact on interpersonal relationships**

3.1 What was your experience disclosing your ED to others (family, friends, work colleagues)?

Follow-up questions:

- What was their reaction? How did you feel?
- How long it took you to disclose it? What were your reasons for not disclosing/disclosing it?
- Did you notice any changes in attitudes towards you after you told them?

- Did you feel any different after disclosing it?
- Did anything change in your relationships (at work/home) after disclosing it?

4. **Beliefs and attitudes associated with gendered roles**

4.1 How would you describe your ED experience as a man? How's that different from a woman with an ED?

Follow-up questions:

- How do you think others see you as a man with an ED? How do you think others see women with ED?
- How would you describe yourself in relation to those traits?
- Have you ever felt labelled in relation to your ED?

5. **Final considerations**

5.1 Is there anything else you would like to talk about that we haven't mentioned?

APPENDIX E: Consent Form

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CONSENT FORM

Title of Study: **“Experiences of eating disorders in men”**

Please initial box

1	I confirm that I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.	
	I understand this will involve	
	• being interviewed by the researcher	
	• allowing the interview to be audiotaped	
2	This information will be held by City as data controller and processed for the following purpose: Preparing reports addressing the research question. Public Task: The legal basis for processing your personal data will be that this research is a task in the public interest, that is City, University of London considers the lawful basis for processing personal data to fall under Article 6(1)(e) of GDPR (public task) as the processing of research participant data is necessary for learning and teaching purposes and all research with human participants by staff and students has to be scrutinised and approved by one of City’s Research Ethics Committees. City considers the processing of special category personal data will fall under: Article 9(2)(g) of the GDPR as the processing of special category data has to be for the public interest in order to receive research ethics approval and occurs on the basis of law that is, inter alia, proportionate to the aim pursued and protects the rights of data subjects and also under Article 9(2)(a) of the GDPR as the provision of these personal data is completely voluntary.	
3	I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation.	

4	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalised or disadvantaged in any way.	
5	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
6.	I agree to the arrangements for data storage, archiving, sharing.	
7	I agree to the use of anonymised quotes in publication.	
8	I agree to take part in the above study.	

Name of Participant Signature Date

Name of Researcher Signature Date

When completed, 1 copy for participant; 1 copy for researcher file.

APPENDIX F: Generating Codes

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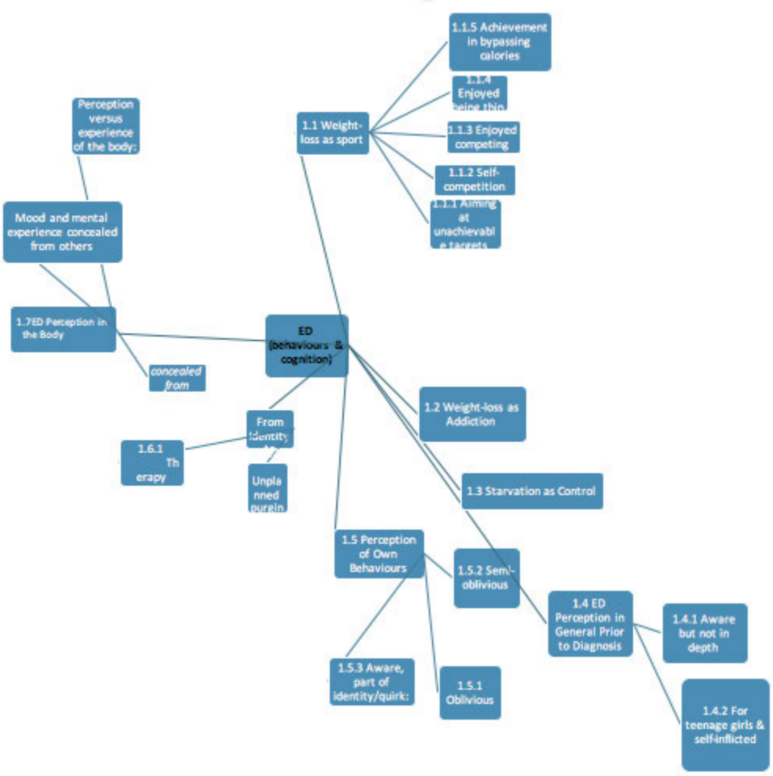
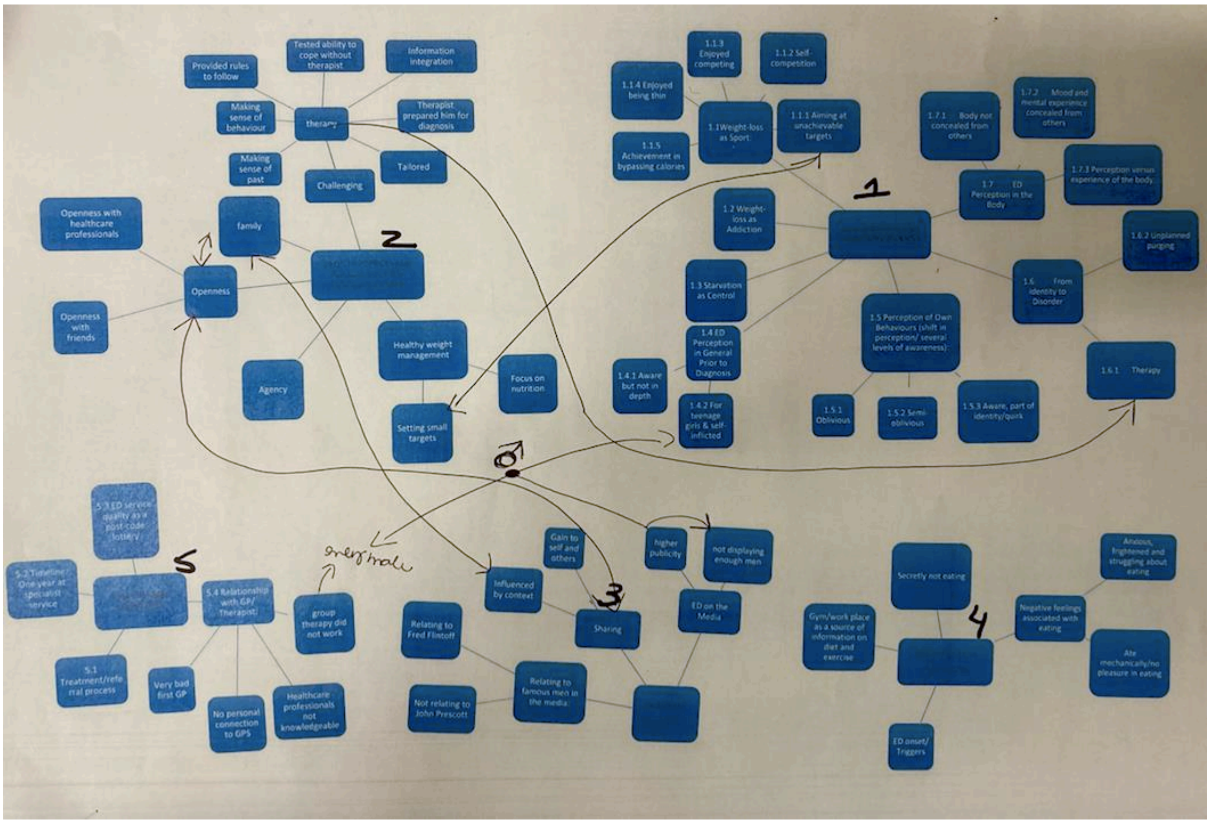
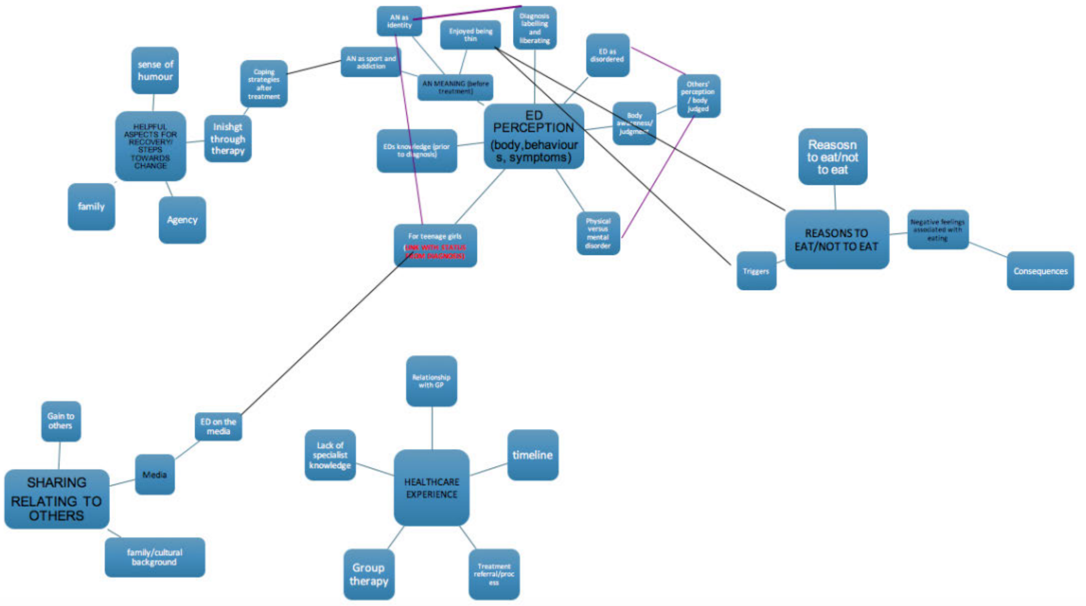
APPENDIX G: Individual initial Map



Appendix H: Individual Final Map



APPENDIX I: Final thematic map



APPENDIX J: Themes with collated data extracts

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SECTION B: COMBINED CASE STUDY AND PROCESS REPORT

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SECTION C: PUBLISHABLE PAPER

‘Men in a woman’s world: experiences of eating disorders in men’

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APPENDIX L

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