

**Chew, Spit and Speak:
Autoethnography and the Eating Disorder World**

by © Shannon Warren

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Abstract

This study focuses on the word “responsibility” as it relates to eating disorders, gender, and the entanglement of the two. Using autoethnography, I write and examine stories that may not have been told in research literature, speak to why they may not have been told, and illustrate the benefits of when they are told. Critical qualitative research on men with eating disorders has grown since the 1990s and has increasingly incorporated the use of stories and experiences as data. Yet rarely does such research offer a client-authored response to medical and popular ideologies of a male with an eating disorder. This study does. Through personal client voice and intersecting researcher voice, this thesis explores the history of one male’s experience of not having space to be seen and heard and when seen, is reduced to a stereotype of gender and client. This study also examines the role autoethnography plays in exploring the male experience of having an eating disorder. As result of this exploration, I offer considerations for future research and treatment discourse on diversifying what is visible, heard, and affirmed in the eating disorder landscape.

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Chapter One

Introduction

1.1 My Story – Welcome and Wait

“Welcome! Come in.”

I was excited.

“I’m Donna, the receptionist,” she smiled and continued from behind her desk, pointing with her arm: “You can walk through this hall and take a left, you’ll see chairs, and you can wait there. If you need anything, let me know.”

I was pumped. I have had an eating disorder for over 20 years, and yes, this was a crappy way to live, but I was excited because it was all about to change. I was in an eating disorder clinic. They knew how to handle this. This was their job. They were experts.

No more physicians telling me all I had to do was take charge of my life, drink beer, and have a few burgers. I was in charge of my life. I had careers as an actor, teacher, and coach, competed as an elite athlete, and coordinated events for charities and film festivals. And I don’t like beer; I’d rather have hot chocolate.

No more social workers and dietitians handing me prescriptive food guides and asking me to follow them. I’ve worked, played and travelled to 10 different countries in the last 10 years. I was now in New Zealand and though I ate cereal and toast for breakfast there, I had eaten kimchi and soondubu jjigae in the morning in South Korea and brioche with Gouda and orange-ginger marmalade in Belgium.

No more psychologists handing me Jenni Schaefer books or *Hungry: A Mother and Daughter Fight Anorexia* (2009) or *The Disappearing Girl* (2013). Not that I didn’t have anorexia and couldn’t identify with the protagonists. It’s just, I was—still am—an adult male.

No more of these things that were not about me. This place, this clinic, had experience. They knew my eating disorder was not about mothers, burgers, or the particulars of what a country should eat for breakfast.

And then Donna smiled. “You know, we had a male psychologist here once,” I heard her say as I walked the hallway and turned the corner. I passed the shelf containing Harriet Brown’s *Brave Girl Eating* (2011) and Grace Bowman’s *Thin* (2008), and books with pastel pictures of teenage girls. I sat in a loveseat with a doily throw, set in front of a painting of purple lilacs.

A male psychologist.

Here once.

Once.

One time, but not anymore. He’s nowhere to be seen in the mix of doilies and lilacs. Or on the list of female professionals I was to see that day.

Fuck.

A loud, scared, and deep “fuck” went off in my head.

And then in my stomach, a familiar feeling.

Vomit.

Once? What about again? I thought.

Again.

Again, I sat and fought the same feeling of vomit.

Not last night’s meal, but my sadness and anger at a history. That all of this had occurred before. Because it had. The fast food of reductionist, gendered, eating disorder treatment, prescribed Cognitive Behavioral Therapy menus and workbooks on perfectionism,

all served in recycled platitude containers advertising “Food Is Not the Enemy,” “Your Weight Is Not Your Worth,” and “Your Life Is Worth More Than Your Eating Disorder.”

Thanks for those life lessons on the boxes. I guess I’m cured now.

But I wasn't. I had in my stomach the vomit of being reduced.

“You know, we had a male psychologist here once” let me know the clinic was aware males are different from females and yet did nothing about it except to say they had done that one thing that one time.

Once, but not now.

So, again, the vomit rose.

The emotional vomit of tension. My gender acknowledged, seen, but ignored. My identity reduced, sectioned, and hacked off as I sat in a place not for me.

The vomit of anger. Of me wanting to scream, yet again, “So, you see me. I am here. But why am I not here? In your posters, books, or on your staff? I’ve gone through your medical referrals, gotten through the intake forms, gone through the back entrance, and pressed the buzzer on the door, and yet nothing is ready. I have check off all the boxes on your checklist, have prepared myself for you, and you have not done the same.”

The vomit of shame. I felt ashamed of my anger because I wanted to be polite to Donna and to those who let me in and because I felt a tension of responsibility. Am I responsible for speaking up? Are they responsible for making space for me to speak? She did ask. What was I to do? I wanted to say, “Excuse me, what about a man working here now? Can you hire another one? How about putting *Skinny Boy* (2007) by Gary A. Grahl, or *Becoming John: Anorexia's Not Just for Girls* (2011) by John Evans, on the shelf? Okay,

these are books about boys. Men have eating disorders. But it's a start. You started once, how about starting again?"

But I didn't say anything because my throat was tired from my history of holding down the vomit. I would have screamed rather than said nice things in a polite tone. My vomit was a harsh mix of anger and sadness, a gross feeling of being thankful yet knowing it's not enough. The sadness of thinking that at least I'm here for all the others who are not. Men in the swimming pool lanes, on bike rides, in the staff rooms, offices and hallways at work—all the names and faces of the men I know who are suffering and were not there. And the sadness that Donna, with her welcome, is trying. My vomit is the feeling of starving: being given a seat at the table with nothing to eat, and being told, "At least you're here."

Except I was not there. I was not in the books on the shelf, not in the staff of the clinic, and not on the posters on the walls. Despite all that was around me, I felt alone.

Sitting in the emptiness, I didn't say anything to Donna because I was holding back all these vomits. I was biting my tongue afraid of my anger and sadness spilling all over her. Donna, trying to do her best work even though the place she was a part of didn't have space for me as a male.

I was deflated. Mouth closed, fighting claustrophobia, fighting anger, fighting sadness, fighting polite, I said nothing.

I said to myself, "Not good enough because I don't tell them. So, they don't know. It's my responsibility to tell Donna that the space may need a male worker or at least a poster with a male on it. Something, anything inviting."

I blamed myself for the emptiness.

And I blamed myself for feeling alone.

In a clinic surrounded by people who were ready to help, I felt abandoned. Like the party was going on, yet I could only get to the window of the house and look in from the outside.

If only I spoke, Donna would know.

But she knew.

“You know, we had a male psychologist here once.”

1.2 Twenty Years of Data

I’ve had an eating disorder for over 20 years and lived in a lot of places: social workers, psychologists, counsellors, researchers, treatment centres — they all know. This research is not to fill a knowledge gap in what they don’t know; it’s not to gender love seats or pink and purple flowers, but to acknowledge the history of the binary in which it sits. It takes a feminist approach in understanding and exploring the gendered nature through which eating disorders are treated. I dismantle the gendered binary that assumes one’s sex traits define their gender identity and that these identities are congruent and dichotomous; it’s the old assumption that males are boys who like blue, and females are girls who pink with no individual identity outside these arbitrary yet culturally definitive posts. And it’s to do so with a male voice; it’s to acknowledge the absence of anyone beyond the narrow eating disorder identity of a cisgender, heterosexual white woman, and call for diversity in the world of eating disorders. It’s to question why nothing is being done despite “here, once.” It’s to look deep into the exclusive, reductionist eating disorder landscape that overlooks a patient's voice and to ask, What now? And to explore a question with a voice that was never given a space to speak.

“If you need anything, let me know,” Donna said as I sat alone in a system built without me.

I will.

1.3 Thesis Overview

This thesis is an exploration of why the introductory story, “Welcome and Wait,” sat hand-scrawled and unedited in a pile of my personal journals destined not to be used as academic research in the first place. It also matches my experience with those of other men in order to deepen an understanding that marginalized voices are not given the space to be heard in eating disorder treatment. Furthermore, it examines the phenomenon that when male voices are finally heard, they are reduced to a gender and client stereotype.

A *client stereotype* is the assumption that as a client I know nothing about eating disorders. It is ideology that assumes I am vulnerable to mass media’s marketing of either a thinness ideal (gendered for females’ bodies) or a muscular ideal (gendered for males’ bodies), am tormented by perfection, and unable to regulate my emotions (Applequist, 2014; Gattario, et al., 2015; Holmes, 2014; Saukko, 2008). A male stereotype is the assumption that the antidote to the above—that is, the cure for my eating disorder—is simply to “man up” and subscribe to Western masculine ideology. This study also chronicles the process of prying open tension within myself that lies in raising awareness among researchers and counselling practitioners of their responsibility to provide an opening for men to express a fuller, more personal story than the reduced and recycled ones currently out there. In doing so, it explores the question, what is the experience of a male with an eating disorder as he engages in research and counselling therapy?

Autoethnography is an autobiographical method of research that reveals personal

experience and connects that experience to wider cultural experiences (Adams, Holman Jones, & Ellis, 2015; Ellis, 2004; Hughes, Pennington, & Makris, 2012; Mcilveen, 2008). It places the author of the research at the centre of self-analysis to describe and further comprehend a multilayered experience; that is, it connects personal experience (the “auto”) to describe (“graphy”) wider sociocultural (the “ethno”) insights (Ellis, Adams, & Bochner, 2011). Researchers have observed that males are marginalized in research and treatment because of stigma and gender stereotypes (Bunnell, 2015; Mitchison & Mond, 2015; Räisänen & Hunt, 2014; Reas & Stedal, 2015; Robinson, Mountford, & Sperlinger, 2012; Strother, Lemberg, Stanford, & Turberville, 2012). Autoethnography is used to shift the perspective from a panoramic view, which positivist methodology has on the topic of eating disorders, to a close-up and insider look at understanding the interactions and tensions within the ethos of gender and client identity.

The perspective presented in this thesis is that it is the responsibility of research and treatment professionals to unbind gender and dissolve stigma so as to open a space that allows for a male voice and client voice to be heard and affirmed. This is a new perspective for me. I knew this in my professional role as counsellor but not as a client in my personal life. As a client, I thought I was at fault for being reduced because I did not speak. This is the problem of marginalization to which this study speaks. In reconciling the silence, I thought I was responsible for speaking, and when I did speak, both in my home journals and in the beginning drafts of this thesis, at times I was apologetic for speaking. By positioning myself as the subject of the research my “personal experience becomes a valid, viable, and vital kind of data from which to make meaning and use in research” (Adams & Manning, 2015, p. 190). This thesis layers my experience as a marginalized and gendered eating disorder client over

what I know is my responsibility as a counselling therapist to enhance counselling practitioners' understanding of gender and client identity and these identities silencing effects on the male client voice.

Autoethnography is a suitable methodology for eating disorder research within counselling psychology because counselling practitioners are trained in person-centred modes of counselling (Jones-Smith, 2014). *Person-centred counselling* affirms the client's personal experience as the basis for therapeutic change. It also assumes that clients have the agency to understand themselves and are capable of "self-directed growth" (Corey, 2017, p.174). In this way, autoethnography and person-centred counselling are mirror processes where an individual's knowledge is valued. Rather than an objective report about a male eating disorder, I offer an inside perspective where my "biased" perspective is embraced and valued as knowledge. By investigating myself in these multiple identities, I am able to produce findings that are relevant to counselling therapists working in treatment capacities to deepen their perspective on the marginalized male experience. Additionally, by writing a male voice into the limited number of research studies regarding men with eating disorders, I am visible for those males who still do not see themselves in the landscape. I remember the first time I read an article and saw a picture of a male with an eating disorder: it meant the world to me not to feel alone. One more voice in the quiet may help those searching to be found.

Mental health literature suggests that listening to the voice of the client fosters healthy client outcomes such as, "being able to control and manage feelings and thoughts, and becoming more self-confident, self-assured and positive" (Gillard, Turner, & Neffgen, 2015, p. 9). These researchers also suggested that these thoughts and feelings become an integral part of what we—as a collective: researchers, practitioners, clients—use as knowledge in the

treatment process. Gillard, Foster and Papoulias (2016) offered a knowledge-translation framework in health care that values the client's experiential knowledge. *Knowledge translation* is a broad term in health care that encompasses the mobilization of research evidence to clinical use (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012). It involves the client as an expert source of knowledge and considers the client's lived experience as relevant to how the collaboration of researcher, practitioner, and client can equally inform and navigate recovery (Gillard et al., 2016). Arguably, then, silence is not the best option for mental health—the client voice is needed. As such, this study is a benefit to the field of counselling psychology where researchers and clinicians study, educate, and practise the art of listening to and affirming a client to better actualize healthy outcomes (Egan & Reese, 2018; Gillard et al., 2015; Joseph & Murphy, 2012; Sweeney et al., 2019; Tilsen & Mcnamee, 2014).

Cohen, Manion, & Morrison (2007) suggested that the purpose of critical theory is to “emancipate the disempowered [and] to redress inequality” (p. 26). This thesis takes a critical theory and feminist approach to understanding and exploring the ideologies of power and gender through which eating disorder research and treatment are addressed. This is to say, while I present a male voice against a backdrop of a female-centric landscape, I do this to acknowledge the absence of equality both in identities of power and gender. I argue that researchers and helpers have a responsibility to deconstruct gender and power by listening more intently to both a client voice and a male voice. For this, autoethnography is needed as a research method because it privileges a voice not often heard in the eating disorder landscape.

I am not alone in being alone. The literature review in Chapter 2 begins with my

experience of not being seen. I then pull back the lens to let current literature tell a wider story, the problem of other men also being marginalized. As the literature review will attest, other men suffer in silence with eating disorders. The autoethnographic self is quickly broadened into the ethnographic *we* when literature says I am not alone (Mitchison & Mond, 2015; Räisänen & Hunt, 2014; Reas & Stedal, 2015; Robinson et al., 2012; Pettersen, Wallin, & Björk, 2016; Strother et al., 2012).

The methods section in Chapter 3 describes what autoethnography is and why it is needed to express and understand my marginalized voice. This section will also layer my personal story of becoming a researcher with panoramic views from other autoethnographic researchers. Anderson (2006) described differences between analytic autoethnography and evocative autoethnography. Anderson suggested that *analytic ethnography* represents a traditional scientific approach where objective writing and analysis are still considered as part of reposting the research. This is in contrast to *evocative ethnography* where the research seeks empathy and resonance from the reader (Adams et al., 2015; Bochner & Ellis, 2016). Ellis and Bochner (2006) argued,

If you turn a story told into a story analyzed...you sacrifice the story at the altar of traditional sociological rigor. You transform the story into another language, the language of generalization and analysis, and thus you lose the very qualities that make a story a story. (p. 440)

This study is both evocative and analytical. Each chapter is led with an “I story” that is followed by analysis. Presented in this way, my thesis allows for a vivid account of my lived experience and an analysis of the climate in which that experience sits.

In “Missed Opportunities,” the lens is focused back on near-self experience to detail what missed opportunities look and feel like from the inside. It is an exploration of how eating disorder research and treatment exclude and reduce a male client voice.

In “Future Directions,” the product of my autoethnographic process is articulated. The process of doing autoethnographic research produced lessons learned from moving the silenced voice to an apologetic voice to an expert voice. It is with this expert voice that attention is drawn to lessons learned from combining lived experience with the experiences of others, and ask for new directions in both eating disorder research and treatment.

1.4 Definition and Location of Terms

This thesis is autoethnographic in method and post-structural feminist in design. Adams and Manning (2015) suggested that “to do autoethnography means recognizing that personal experience cannot be easily or definitively separated from social and relational contexts” (p. 190). Post-structural feminism argues for the expansive nature of all identities and allows for acknowledgement of how fluidity of identities develop in relation to various contexts, and in particular to this study, the social construction of gendered identities and health identities (Beausoleil & Petherick, 2015; Randall, 2010). Words such as “eating disorder,” “man,” and “female” are nuanced, and the context in which I use them in this thesis must be attended to. When the receptionist, Donna, smiled and said, “You know, we had a male psychologist here once,” I was very aware of my gender. I was pulled away from being Shannon and placed into a box of gender that left me without personal agency. Questions like “What is an eating disorder?” and “What is a man?” will be answered differently by everyone; therefore, context matters when research and treatment attempt to speak to diversity.

1.4.1 Shannon’s Autoethnographic “Man” Eating disorder media speak in a limited gender binary, marginalizing individuals who are transgender or have an identity such as gender nonconforming, genderqueer, gender variant or agender, or non-binary (Bowmen, 2018;

Diemer, et al., 2018; Gordon, Austin, Krieger, Hughto, & Reisner, 2016); ethnicity (Becker, Franko, Speck, & Herzog, 2003; Cachelin, Rebeck, Veisel, & Striegel-Moore, 2001; Marques, et al., 2010); and (dis)ability (Roosen, 2017). I am cisgender, heterosexual, able-bodied, white, and male so my autoethnographic research will speak directly to that lived experience. While the scope of my lived experience is as such, I use the term “Man/Men” as a character beyond my personal experience to include those who identify as a male. I cannot speak for other experiences in the gender galaxy, other ethnicities, or diversely abled people through this autoethnographic study; however, the above-cited articles have acknowledged such an absence. This is to say, I will speak from my specific and privileged vantage point while acknowledging the absence of diversity. Placing myself as the subject may be seen as a limitation of the research in that I have chosen to consider my own voice over those of other people whom I came in contact with; however, this inquiry is not focused on the helper’s perspectives on working with people with eating disorders. Rather, it focuses on my own experience with those helpers and embeds my experience among that of other males who have also experienced oppression from power and myths of masculinity.

1.4.2 Research. As Susan Bordo (2009) suggested, eating disorder research was once focused on white, middle-to-upper-class women from the ages of 18 to 35. As the literature review will demonstrate, not much has changed since. Therefore, *female* still signifies predominantly young, white women in relation to eating disorders. Here, *research* refers broadly to peer-reviewed qualitative studies. The descriptor “broadly” is used because there is one other autoethnographic thesis from a male in Canada, Theodore Christou’s 2009 *Dead, Shed Skin: An Autoethnography*. Three narrative studies in Canada explore men’s issues with eating disorders. Ryan M. Ashuk (2004) wrote his master’s thesis *Narratives of Males with*

Eating Disorders and interviewed two males for his research. Katherine Vanden Elzen (2018) interviewed five men, including me, for her master's thesis, *The Sport Body Image Project: Exploring Body Image Among Athletes in Newfoundland and Labrador*. In 1995 at Memorial University, David Philpott wrote a master's thesis, *More than Mere Vanity: Men with Eating Disorders*. Philpott's thesis was written over 20 years ago, and much of what his research speaks to remains unchanged in today's eating disorder landscape and today's Western ideologies of masculinity. Below is a snapshot of pages 12 and 13 (Figure 1.1), which present men as unseen in eating disorder treatment and masculinity as a reason for being unseen. Text such as "help is not socially accepted, much less encouraged by men," "prominent ideals in our culture is that men are supposed to be strong enough...to handle their problems on their own," and "misleading stereotype of the kind of person who has an eating disorder: young, white, upper middle class, and female" were written in 1990 and 1991. These comments are still valid in 2019.

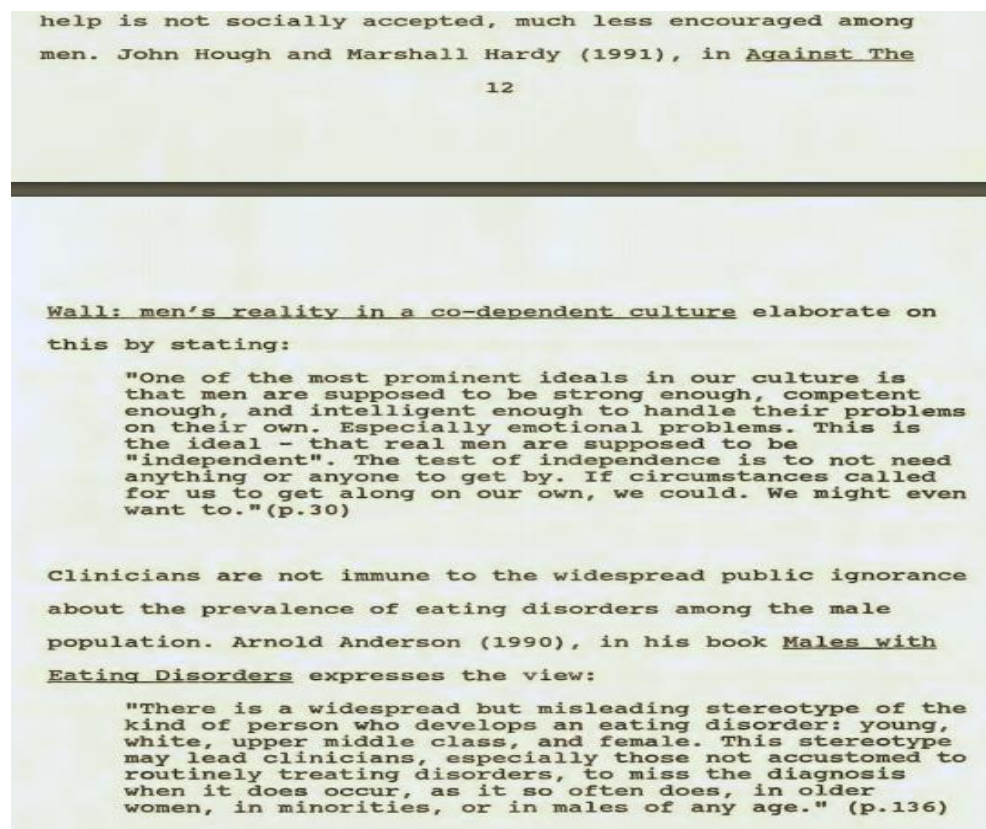


Figure 1.1. 1990 research Screen capture of “More than mere vanity: Men with eating disorders,” by D. Philpot, 1995, pp. 12–13. Reprinted with permission of David Philpot.

1.4.3 Helpers/ Counselling therapists. The term *helper* is used inclusively to refer to

professions that are in a position to help those with eating disorders; for example, their roles are those of psychologist, social worker, counsellor, nurses, and physician. *Counselling therapist* refers to only those who are trained in psychotherapy: for example, psychologists, social workers and counselling therapists and therapists.

1.4.4 Eating disorders. Medical literature, critical theory, and social media characterize eating disorders in a spectrum and variety of ways. While the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013)* is used in the medical field to diagnose an eating disorder, other researchers and practitioners deliberate more nuanced definitions of eating disorders (Pini et al., 2016; Thomas & Schaefer, 2013). Pini et al (2016) suggested that an eating disorder spectrum “involves core, atypical, and subclinical symptoms and signs, temperament and personality traits, and behavioral patterns that, as a whole, represent a range of psychiatric symptomatology linked to eating disorders” (p. 1656). Questions such as “What is defined as ‘atypical,’ ‘subclinical,’ and ‘personality traits’ and ‘symptomatology linked’” build a strong case for understanding eating disorders in a variety of contexts.

The authors of the *DSM-5* made changes from the *Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV; APA, 1994)* to better specify the particulars of anorexia nervosa and bulimia nervosa, and they added the category *binge eating disorder*. They did so because under the *DSM-IV* many Americans were being diagnosed under the umbrella term *eating disorder not otherwise specified* (EDNOS; APA, 2013). The APA suggested that a more accurate diagnosis of eating disorders is valuable in defining a treatment plan for clinicians and patients (2013). The APA also added *binge eating* as its own category to

increase awareness of the differences between binge eating disorder and overeating (APA, 2013).

The changes made in the DSM-5 are important to note because, in light of its broadened and more detailed scope, critical theory is needed to help understand other prominent eating-problem phenomena that the *DSM-5* still does not characterize in a way that lends itself to diverse diagnosis and treatment.

1.4.5 Theoretical definitions. Researchers and theorists seek to widen the scope of what eating disorders are further than the *DSM-5* by characterizing eating phenomena that lie outside of anorexia, bulimia, and binge eating. These disorders, most often called *disordered eating*, stem from extremes of *healthism*. Crawford (1980) introduced this term to suggest that the problem of health and disease lies at the level of the individual; therefore, it is up to an individual to take responsibility for their own exercise and diet rather than the medical community. Crawford did not coin the following terms; rather, the schema for extremes in exercise and diet are seen in the following. *Almost anorexic* describes those who are not underweight but have negative emotions in relation to food (Thomas & Schaefer, 2013). *Orthorexia* describes those who may not be underweight but are burdened by seeking a theology of “clean eating” or eating the “perfect food” (Bundros, Clifford, Silliman, & Neyman Morris, 2016; Dunn & Bratman, 2016; Missbach, Dunn, & König, 2017; Simpson & Mazzeo, 2017). *Muscle dysmorphia*, *reverse anorexia nervosa*, *bigorexia* and *manorexia* are, depending on the literature, interchangeable terms that refer to when an individual is obsessed with certain parts of their body not being muscular and large, often leading to steroid use or excessive amounts of time adhering to strict muscle-building activities (Pini et al., 2016; Pope, Phillips, & Olivardia, 2000; Tod, Edwards, & Cranswick, 2016). *Muscle dysmorphia*

specifically is in the *DSM-5* as a body-dysmorphic-disorder subtype though there is scholarly debate about placing it under eating disorders. The *DSM-5* diagnostic criteria state that one may have body dysmorphic disorder if one's condition is not better explained by diagnostic criteria for an eating disorder. Yet, the *DSM-5* then continues to say that individuals with muscle dysmorphia “diet, exercise, and/or lift weights excessively, sometimes causing bodily damage” (p. 243). Here it is evident that an ambiguous grey zone exists where muscle dysmorphia is not considered an eating disorder yet having the condition means one is dieting enough to cause corporal damage. Pini et al. (2016) argued that, therefore, placing muscle dysmorphia under eating disorders may enable clinicians to better assist those with the condition.

This grey zone extends beyond the semiotics of whether muscle dysmorphia is a body issue or an eating disorder issue. Nuances of the human condition are acknowledged in the *DSM-5*'s “Approach to Clinical Case Formulation”: “the range of genetic/environmental interaction over the course of human development affecting cognitive, emotional and behavioral function is virtually limitless” (p. 19). However, in its “Feeding and Eating Disorders” chapter, the *DSM-5* states that its eating disorders classifications are “mutually exclusive” because “despite the number of common psychological and behavioral features, the disorders differ substantially in clinical course, outcome, and treatment needs” (p. 329). This incongruity, that genetic and environmental factors in human development is “virtually limitless” yet eating disorders are classified as “mutually exclusive,” is an argument for why researchers, practitioners, and those with “almost anorexia” need a discourse in which to speak to those instances when the *DSM-5*'s inconsistency may exclude an individual's eating-problem experience.

Pini et al. (2016) argued that eating disorders and disordered eating be considered as a spectrum. They said that often “symptoms may develop as prodromes to a full-blown disorder or occur as vulnerability factors for the development of a not-yet-fully expressed disorder, or as sequelae of a previous disorder” (p. 1656). In other words, an individual might begin as “almost anorexic” and progress to the *DSM-5*’s description of having full-blown anorexia. By seeing the individual as on a spectrum, early interventions may be sought out and utilized (Pini et al., 2016).

I am agnostic about the diagnosis of what others define as an eating disorder. While “agnostic” is often used to describe a position in relation to religious beliefs, in this instance it means I have neither faith nor disbelief in the medical or theoretical ways of defining eating disorders. This means that for those who need a *DSM-5* diagnosis, I understand why they may need one. For example, often a diagnosis is needed to receive intensive medical treatment or entrance into an inpatient program (Mehler & Andersen, 2017). It also means that I understand why someone may wish to describe their eating disorder experience through a theoretical or alternative lens; for example, to recognize their need to seek help regardless of a clinical diagnosis (Mehler & Andersen, 2017; Thomas & Schaefer, 2013). Research suggests that individuality and personal experiences should be privileged throughout diagnosis and care, both in medicine and in counselling psychology (Bohart & Tallman, 2010; Charon, 2008; Defenbaugh, 2008; Gibbs & Franks, 2002; Maggio, 2014; Tilsen & Mcnamee, 2014).

In the same way I use autoethnography to place my voice in my hands, so too, I reason, may individuals define what an eating disorder is within themselves. I was a summer-stock actor in Trinity, Newfoundland and Labrador, where some of my friends had “coffee and cigarettes” for breakfast. At any one breakfast meal someone makes a decision to eat

cereal or toast or egg —or two organic bananas in their green detox smoothie. The myriad of factors informing those choices and the psychological and pathological consequences of acting on any one of those choices can quickly become complex. Cathy and Fred had no qualms whatsoever about their “coffee and cigarettes,” whereas I could not find skim milk and lost my head about it. Out of the three of us, I was the one who ended up in the hospital with blurred vision, a pounding headache, and an intravenous feed in his arm. Because of my experience, I side with those theorists (see Thomas & Schaefer, 2013) who argue for turning the meaning of an eating disorder over to each individual, who needs to define it as they see fit. Often, I was not anorexic enough for a public health care professional to help me.

My agnostic approach to eating disorder diagnostics is also not to suggest a “truer” definition based on my experience than that proposed by medical terms. Rather, it is to underscore my personal account of what it means to have anorexia and orthorexia. I understand practitioners, especially those in the medical field, need clearly defined parameters of diagnostics. I acknowledge and do not trivialize the need of certain patients who require intensive medical attention as eating disorders have a mortality rate “significantly elevated as compared to the general population” (Fichter & Quadflieg, 2016, p. 401). Those with eating disorders often suffer from physical conditions such as heart defects, low fertility, muscular weakness, gait and eye abnormalities: severe cases of eating disorders can result in death (O’Brien, Whelan, Sandler, Hall, & Weinberg, 2017; Papadopoulos, Ekbom, Brandt, & Ekselius, 2009). Research indicates that the prevalence of eating disorders in Canada as of 2013 was between 2% and 3% of the population, while “little [was] known about the incidence and prevalence of eating disorders in certain populations, including children and youth, ethnic and visible minorities, First Nations people, and sexual and gender minorities”

(Canada. Standing Committee on the Status of Women, 2014, p. 7).

In light of contextual theories of eating disorder definitions, because the experiences unpacked in this thesis happened in clinics with medical doctors and other eating disorder specialists, the words “eating disorder(s)” herein will be used to mean anorexia, binge eating and orthorexia, and will pertain to those who do not need immediate and intensive medical help.

1.4.6 Medical diagnosis. *Anorexia nervosa* is a condition defined as persistent restriction of calories leading to significantly low body weight; either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain; a disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight (APA, 2013)

Binge eating disorder occurs when large amounts of calories are consumed, and no action is taken to try to eliminate the calories. According to the *DSM-5*, binge eating episodes are associated with three or more of the following:

eating much more rapidly than normal, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, eating alone because of feeling embarrassed by how much one is eating, feeling disgusted with oneself, depressed or very guilty afterward. (APA, 2013, p. 350)

Bulimia nervosa occurs when large amounts of food are consumed with a sense of lack or control over eating and an action is taken to try to eliminate and/or burn the calories just consumed; for example, “self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise” may be used to compensate (APA, 2013, p. 345).

Avoidant/restrictive food intake disorder (ARFID) occurs when an individual does not meet appropriate nutritional and/or energy needs associated with one or more of the

following:

loss of weight or failure to achieve acceptable weight for age, significant nutritional deficiency, dependency on enteral feeding or nutritional supplements, or a noted interference with cognitive and behavioral performance because of avoiding and/or restricting food.

The *DSM-5* also states, “The behavior does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way one’s body weight or shape is experienced” (APA, 2013, p.354).

Other specified feeding or eating disorder (OSFED) occurs when one does not meet all of the criteria for anorexia nervosa, bulimia nervosa, binge eating disorder, or ARFID yet still presents eating behaviours that cause clinically significant distress and impairment of functioning. (APA, 2013).

Unspecified feeding or eating disorder occurs when one’s food related behaviours cause clinically significant distress/impairment of functioning but do not meet the full criteria of any of the feeding or eating disorder criteria or OSFED criteria. The *DSM-5* suggests this category may be used by clinicians when there may be insufficient information to make a more specific diagnosis (APA, 2013).

1.4.7 Literature. My definition of *literature* is autoethnographic in nature. Included in the literature review are online magazines, eating disorder websites, and social media (that is, Facebook and Instagram) as well as scholarly, peer-reviewed articles. I review social media because what people with eating disorders see about themselves in media has an impact on help-seeking (Strother et al., 2012; Räisänen & Hunt, 2014; Robinson et al., 2012). It influences how they identify as “anorexic” or bulimic” or “orthorexic” as they move through the complicated milieu of eating disorders, disordered eating, and healthism, and can have a negative impact on their ability to seek help and engage in good-fit treatment (Håman,

Barker-Ruchti, Patriksson, & Lindgren, 2015; Lee & Macdonald, 2010; Thomas & Schaefer, 2013). Therefore, including media images for critical analysis is important to understanding how eating disorder ideologies are perpetuated.

Table 3
Binomial logistic regression predicting remission rates at 12-month review assessment based on intake perfectionism ($N = 75$).

	β	SE	Wald	df	p	OR [95% CI]
EDI-P	-0.55	0.26	4.63	1	< 0.04*	0.58 [0.34, 0.97]

Note. EDI-P = Eating Disorder Inventory - Perfectionism scale, β = Beta Coefficient, SE = Standard Error, df = Degrees of Freedom, OR = Odds Ratio, CI = Confidence Intervals.

* $p < 0.05$.

Figure 1.2. Perfection scale. Screenshot from “Perfectionism is associated with higher eating disorder symptoms and lower remission in children and adolescents diagnosed with eating disorders,” by J. Johnston, C. Y. Shu, K. J. Hoiles, P. J. Clarke, H. J. Watson, P. D. Dunlop, & S. J. Egan, 2018, *Eating Behaviors*, 30, p. 58. Reprinted with permission from Elsevier

For example, Figure 1.2 (above) tells a story of eating disorders and a group’s recovery from perfection. As do the other images from Instagram (Figures 1.3, 1.4 and 1.5).



Figure 1.3. Look of recovery. Screenshot of I’ve worked relentlessly to overcome obstacles and build my strength... [Instagram photograph], by B. Burgunder [@brittany burgunder], November 28, 2018 (<https://www.instagram.com/p/BqvONecn7D5/>). Reprinted with permission from Brittany Burgunder.

Figure 1.3 (above) is from an Instagram site where a certified professional coach specializing in eating disorders shows what recovery looks like for her and, in turn, for her clients. A “look” of recovery is not uncommon on social media.

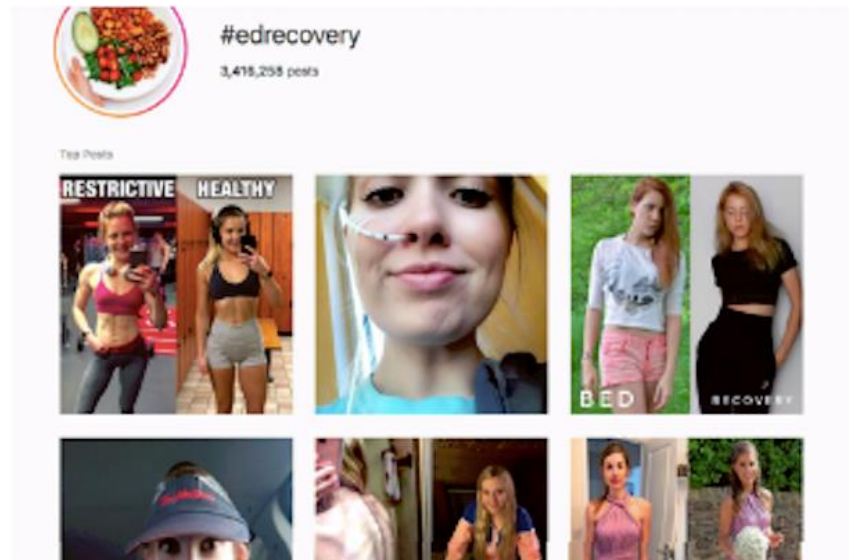


Figure 1.4. Recovery looks like – #1. Screenshot of search using “#edrecovery” [Instagram photograph], by [Multiple authors], February 7, 2019, (<https://www.instagram.com/explore/tags/edrecovery/?hl=en>). Reprinted under Fair Dealing Guidelines.

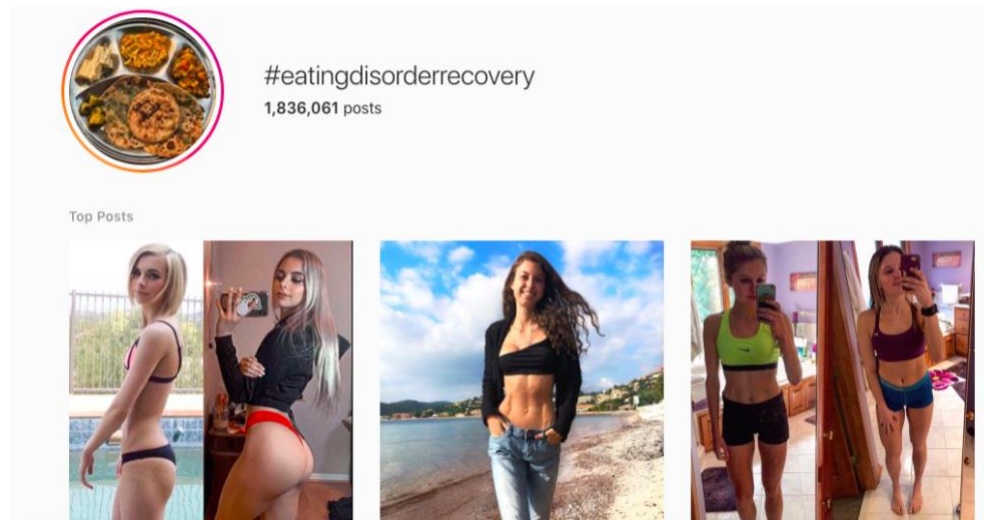


Figure 1.5. Recovery looks like – #2. Screenshot using “#eatingdisorderrecovery” [Instagram photographs using “#eatingdisorderrecovery” search], by [Multiple authors], February 7, 2019 (<https://www.instagram.com/explore/tags/eatingdisorderrecovery/?hl=en>). Reprinted under Fair Dealing Guidelines

The above images are what people with eating disorders are considering and consuming as knowledge, for what it is like both to have an eating disorder and to go through treatment.

While randomized control trials are considered the gold standard of clinical research (Andrew & Halcomb, 2008), online magazine and social media posts offer to tell the stories of what is happening outside the clinics or hospitals. By examining the user-created content of social media, we shift positions on what is seen and, therefore, make known what otherwise might be hidden. This is not an argument to nullify a literature review of academic peer-reviewed scholarship; rather, it is to acknowledge the need to include other literature that people with eating disorders encounter in their environment. For males with eating disorders, the dominant images around us are not us at all.

Chapter Two

Literature Review

2.1 Literature Overview

This literature review is in two parts: “Literature Lived” and “Literature Reviewed.”

“Literature Lived” is a narrative that evokes an insider experience of what it is like not to been seen in the literature, the literature apparently about me, someone with anorexia.

“Literature Reviewed” is written as a graduate student researching and writing this thesis, where I group the literature into themes that speak to a male client experience. This division of the literature review illustrates how autoethnography can indeed offer the “auto” experience of a culture; this is to say, rather than be at “arm’s length” from literature about eating disorders, at times I found myself in the middle of it.

2.2 Literature Lived

My first literature review was as a massive sigh of relief.

In 2005, I was a substitute teacher and filling in for a Healthy Living class. I stood in the back of a dim-lit classroom as we watched the documentary *Dying to be Thin* (McPhee, 2000). In it, Susan Sarandon’s voice narrated a script about anorexia over scenes of white teenage girls dancing ballet. This is what my first engagement with eating disorders looked like from the outside.

White-skinned, teenage girls.

I liked watching the movie because it reaffirmed what I’d seen in the media in years past: eating disorders happened to young girls. I was a 25-year-old, broad-shouldered man. I went to the gym and ate pizza. Awesome, I saw from this documentary that I did not have an eating disorder because I didn’t wear pink tutus and I didn’t go days without eating.

Never mind that years earlier I had to sit on folded towels on chairs so as not to scrape my sit bones, my skin was so paper-thin that friends asked if I had cancer, and I had constant headaches from craving food. Point was, I was a dude, I did not, and could not, have an eating disorder.

Now, to be fair, Susan did say, “Today, some eight million people, mainly women but some men, suffer from anorexia and bulimia, a related disorder. Young women, ages 15 to 24, are the most vulnerable” (McPhee, 2000).

I began to worry. Okay, some men do have eating disorders. But as doctors were interviewed—Erin, Ruth, Megan and Katy—my wave of fear was short lived because they spoke about people with anorexia wanting to be perfect. Dr. Kaye said, “From a biological standpoint we're actually finding that people with these disorders actually share some common personality traits. And that is both bulimics and anorexics tend to be people who are obsessional, perfectionistic. And they are concerned about doing things right. Things have to be done kind of with symmetry and exactness” (McPhee, 2000).

Again, I sighed with relief.

I am not a perfectionist. I’m often late for meetings, can never find my car keys, and haven't got a clue where I put that frigging piece of paper with whatshisname’s phone number on it. I barely passed math in high school or psychology in university. I can’t spell and hardly ever wash my hair. I’m certainly not a perfectionist.

Which is great. In that classroom, I learned that because I’m an untidy, unorganized adult male, I didn’t have an eating disorder.

Never mind when years earlier even my skinny, stretchy Lycra bike shorts became too big for me, eating as much as one egg a day sent me into a wretched downward spiral, and I

rifled through a dog-eared calorie counter book more times than I spent on writing papers in university.

I wasn't an emaciated 16-year-old white girl as seen on TV.

I was a male.

I am a male.

I was ok.

Accepted.

Except,

I was not ok.

In 2013, my second wave of unintentional literature reviews came in the darkness of an office adjacent to the classroom in South Korea where I was working as a teacher. The lights were off in the classroom, and all that shone was the flicker of the desktop computer.

I was lonely, hurt, and afraid.

My throat burned from candy sugar running down it. My stomach was bloated and acidic from gas created by plunging a box of Snickers bars into my mouth and back out again. Meanwhile, it wasn't my body that hurt the most; it was mind and soul— self-worth and morality. My fingers were cold and shaking as I typed my first keywords in what would be my next wave of a literature review.

“Chewing and spitting.”

I thought I could help myself with my problem.

Daily, I chewed mass quantities of food, held it in my mouth and spit it out in a garbage can, toilet, or my hand. Tubs of ice cream. Boxes of Snickers bars. Bags and bags of

nuts. Full cakes. I thought I had beat the restriction I had years prior by allowing the ecstasy of food in my mouth without having to digest it.

Nobody knew.

I did it alone in my bathroom.

Eventually, I did it in public.

I became apt at chewing and spitting into napkins, pretending to cough or slowing down behind my friends to throw my spit chocolate bars into the bushes that we passed. I became obsessive about it. I couldn't wait to get home from a three-day yoga retreat to do it. I sometimes passed up on meeting friends because I need my fix of chewing and spitting.

As I typed the words “chewing and spitting” into my Google (re)search, I found my first sliver of comfort. Others had done it too (Figures 2.1 and 2.2). I was not alone.

Chewing and spitting was a thing that others did.

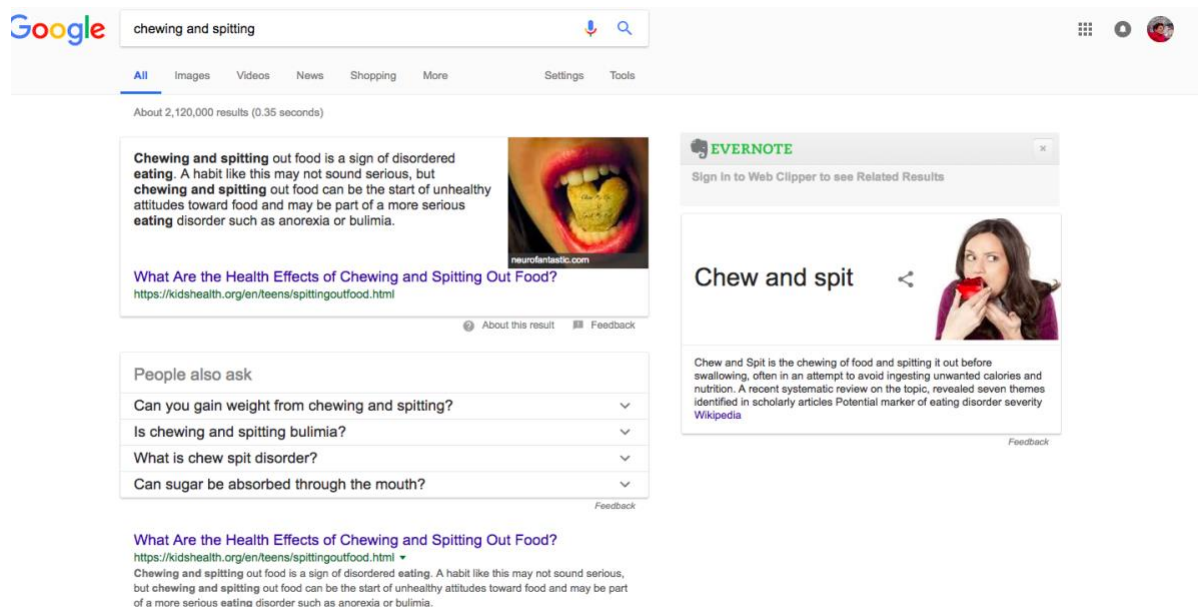


Figure 2.1. Chew and spit. Screenshot of Google search using search term “chewing and spitting”. Retrieved February 3, 2019 from [https://www.google.com/search?q=chewing and spitting&rlz=1C5CHFA_enCA693CA693&oq=chewing and spitting&aqs=chrome..69i57j0l5.7067j0j8&sourceid=chrome&ie=UTF-8](https://www.google.com/search?q=chewing+and+spitting&rlz=1C5CHFA_enCA693CA693&oq=chewing+and+spitting&aqs=chrome..69i57j0l5.7067j0j8&sourceid=chrome&ie=UTF-8) Google and the Google logo are registered trademarks of Google LLC. Used with permission.

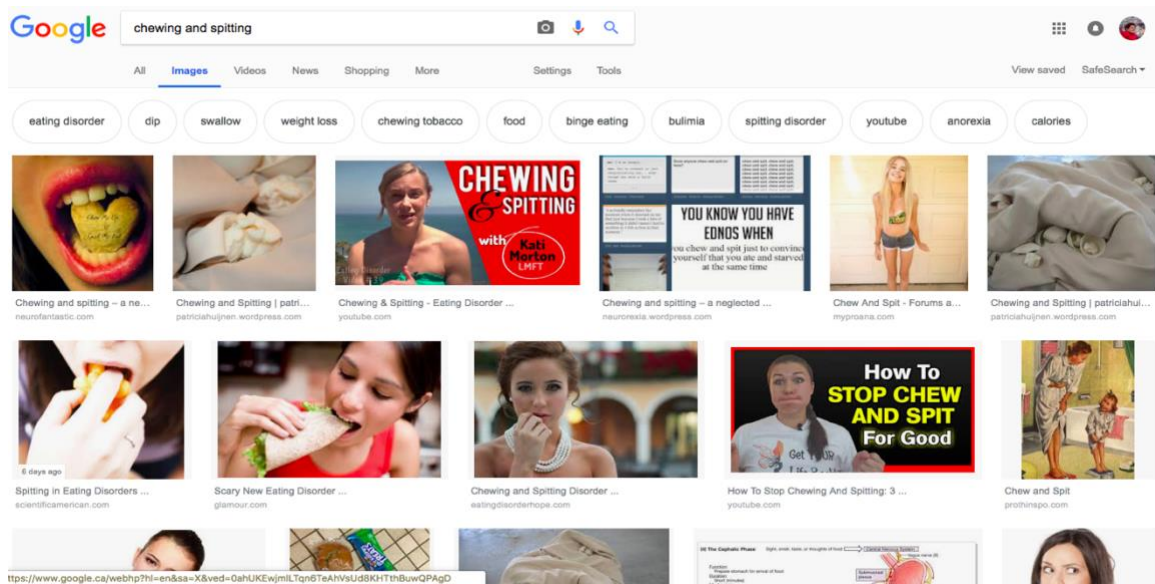


Figure 2.2. Chew and spit images. [Google Search of images using the term “chewing and spitting”]. Retrieved February 3, 2019 from [https://www.google.com/search?q=chewing and spitting&rlz=1C5CHFA_enCA693CA693&oq=chewing and spitting&aqs=chrome..69i57j0l5.7067j0j8&sourceid=chrome&ie=UTF-8](https://www.google.com/search?q=chewing+and+spitting&rlz=1C5CHFA_enCA693CA693&oq=chewing+and+spitting&aqs=chrome..69i57j0l5.7067j0j8&sourceid=chrome&ie=UTF-8). Google and the Google logo are registered trademarks of Google LLC. Used with permission.

Yet, yet I was still alone.

The others who chewed and spat were indeed others. They were not me.

I saw articles and websites of young white women. Websites that said eating disorders discriminate against no one, but here I was looking at a woman and reading about loss of menstrual cycles and fear of getting large hips. I felt alienated enough in my arena of friends because of the secrets of chewing and spitting that I held. I didn’t need yet another exclusion because of my gender.

A sigh of half relief. “Okay, I don’t have a problem. I’m not here, so I can’t have a problem. I don’t need to talk to someone about whatever it is going on with me because it doesn’t exist. I mean, clearly, chewing and spitting exists. What I mean is, I don’t exist in it.”

I try to top myself up to a full sigh of relief.

No such luck. “Why do I still feel like shit? I’m not on these webpages. Maybe I don’t have an eating disorder problem? But I do, don’t I?”

I begin to doubt myself.

Maybe I'm making up my hurt and fear and shame? Maybe I need to just stop chewing and spitting? That's it. Just stop. Maybe I'm making the whole conundrum of it up. The times I've starved myself. The times I have fought battles tooth and nail in my head to not eat dessert, any dessert. The times I've avoided fats at all costs. The times I've avoided carbohydrates at all costs. The times I've avoided neither and duct-taped up my food in small proportions and hid them in the shed. Maybe I've made all that up.

I search again.

For myself.

The pain in my stomach is real. Real from the rush-in-and-purge-out of Halloween chocolate bars and real from the isolation of non-existence.

So I searched again.

Perhaps I need to be more specific. Perhaps there are eating disorders. And then there are eating disorders for men. Perhaps there are eating disorders for people who are transgender. Perhaps there are eating disorders for those over 50. Perhaps there are eating disorders for people of colour. Perhaps eating disorders exist by compartments.

I typed another informal literature review—I googled “eating disorders” plus “men.”

News articles on Dennis Quaid popped up.

Various news sources reported that Quaid's issues began when he lost 40 pounds to play Doc Holliday in the 1994 movie *Wyatt Earp*. The Hollywood actor became obsessed with counting calories and excessive exercising. The sources reported that Quaid eventually sought help with regaining his strength and has since recovered (Boodman, 2007; Peterson, 2006).

Ok. Cool, I thought. Men get eating disorders too. If Dennis Quaid can have an eating disorder, then so to can I.

I didn't feel as alone.

For the first time, I saw myself.

For the first time, I felt as if I wasn't making it up.

That the extreme and unhealthy weight loss from years earlier, the hyper-restrictive dieting I had done in years since, and the chewing and spitting I was doing now was all real.

As I sit in 2018 and write about this past time, I'm about to say, "I saw a light at the end of a tunnel," and I almost erase that sentence because it's cliché. I keep it on the page because it's not the light that's important to me upon reflection—it's the darkness of the tunnel. I thought I had created my own darkness, that it was all in my head, and that I was the sole proprietor of my miserable experience. And it's not that seeing Dennis Quaid allowed me to blame someone else or hold anyone else responsible. It simply meant that the darkness was shared, and I wasn't the first one to go into the tunnel. Being seen in the literature was important.

Still, my literature review was a full sigh of relief.

My deep breath in the back of the classroom in 2013 gave me the courage to call Marie, my close friend in Canada. I wasn't ready to tell anyone sitting in the same room as I was; I wanted to talk about it and be able to compartmentalize it. After talking to Marie, I had the courage to tell two close friends in Jeju. This, in turn, led me to my relationship with Joan.

Joan was a clinical social worker at a hospital in the U. S. with over 30 years of experience in eating disorder mental health, and mental illness, but it wasn't for her to show me what she knew about health and illness.

Once a week through Skype, she and I, moment by moment by moment, took apart, researched, created, and created again. She understood that through our relationship new knowledge was created, meaning made from it and actions are taken from it. Good-fit counselling is like improv. An improv actor prepares by playing games to strengthen muscles enough to relax them when going into a scene and letting the relationship do the work. This is what Joan did. She and I were able to let our relationship do the work. This counselling was personal. Relentless searching, discovery, meaning making, adaptation, and action.

This was researching and this was creating. I learned that my eating disorder is not iliotibial band syndrome. It's not contained to my one body part or component of me. There's no eating disorder without a living, breathing human. I had to learn about me. I closed my laptop on traditional research and scholarly ways of knowing and dug deep into relationships and connections with myself and with Joan and with my friends.

After six months of counselling, Joan and I finished our sessions because I was moving to another country. We had also accomplished deep, moving, and sustaining work that carries with me today, and it felt like the time to move on. We worked on the whole me. My friendships grew stronger, I was relentless in loving myself and embodying what that meant and looked like for me. We had done good work.

And, yet, for all the necessity of our relationship and researching, the unintentional process of autoethnographic research also began in that same time. I still wanted to answer the question "Is it just me and Dennis Quaid?" when it came to seeing myself in eating disorder literature.

In 2016 I became a graduate student at Memorial University of Newfoundland. I had been there as a student in 2003 as an undergraduate completing an intermediate/secondary

bachelor in education. I hated it. Hated sitting in desks all day. Hated reading books about teaching. Hated sitting at a computer and typing words upon words about teaching. It did not at all match my other undergrad degree in theatre, where we played our days out in rehearsal halls wearing makeup and costumes and our homework was to see plays in London in the evenings. In theatre I was on my feet; in education I was on my butt. I loved teaching, just hated writing about teaching.

I felt this time going on campus would be different. I had wanted to be a counsellor for a while and just didn't have the nerve to think I was good enough to do so. But there I was, I loved theatre for its ability to tell stories and connect people through the process of telling a story. I was eager that in counselling I could do the same. Still, I was apprehensive about the bum sitting and typing words upon words. As I walked towards campus in the rain, I chuckled at the campus entrance sign, "Where people and ideas become..." "Become what?" I scoffed under my breath. "At least finish your sentence."

Fast forward a few weeks and a hint of irony later. I get out of a research methods class where we had just learned about autoethnographic research. I rush to the office of Dr. Sarah Pickett, my academic advisor. I'm not sure what I said on the outside. I remember what I felt I was saying on the inside:

I'm angry all the time. I've got journals and journals filled with anger. And not from my eating disorder. That's secondary. I've got anger from the world that surrounds my eating disorder. Reductionist, pathologizing treatment. Female-centric treatment. And I thought it was all in my head. I thought it was just Shannon Warren making it up, being a crap client, being a grumpy old male going "Woe is me." I thought it was my eating disorder telling me to resist the help. After yet another therapist handed me a book on a mother-daughter

relationship—and I shit you not, this happens to me more than you think—I said, I can’t do this anymore, I’m not here to read a book, I do that on my own, thank you. I can read, been doing it since I was five. And I was told I was resisting again. It’s a common phrase in the eating disorder helping world: “That’s the eating disorder talking.” If I hear that one more time, I’m going to scream. It’s not the fucking eating disorder talking, it’s me—Shannon. Listen to ME.

And the kicker is, it’s not just me. Men in the UK, men in Australia. Men in the U.S. Men in Canada. In Newfoundland. In St. John’s. I swim with them. I rehearse in plays with them. I teach with them. The minute I open my mouth about my eating disorder in the staff room another man begins to mutter and stumble through their story.

And I’m too angry all the time to do nothing. So, can I do something? Because here’s the thing: it’s not all bad. I’ve gotten wonderful help, but it’s in fragments, and I’ve fought hard and made a lot of phone calls and walked away from a lot of poor-fitting treatments, thinking it was my fault for not being ready enough. But I’ve had good-fit relationships before, and I want others to have them too. This, can I tell this story? It’s been told in snippets and dribbles from other researchers. And it’s good work that they are doing. We just need more of it. Thicker of it. I want to tell it thick. Thick enough so that it sticks. So that it sticks, and someone for fuck’s sake listens. Can I do that? Can we do that? Can we research that silent voice and listen to what it says?

And Sarah said, “Yes.” And I become a Researcher. Well, I was always a researcher. But now, not the kind I was in the dark in 2005 but one in the light with a thesis. I was always researching. People with eating problems are researching day in and day out. This time, for me, it was a little more intentional. I began researching for others.

2.3 Literature Reviewed

A brief history of eating disorders provides context and understanding of its current culture. Ideologies of thirteenth-century spiritual starvation and muscular images of men are still part of today's current Western media, where shiny digitally enhanced bodies are displayed on magazine covers. Both history and current public discourse sell the same idea that eating, or not eating, the right foods is a path to nirvana. To be clear, this is not to suggest current, or past, media is to blame for eating disorders. Rather the literature review integrates both the past and present gendered binary of woman and man in relation to eating disorders to suggest that gender stereotype, stigma, and an assumed client identity are factors contributing to the marginalization of men in eating disorder research and treatment. This literature review also establishes that eating disorder research and treatment are perpetuating this gender doctrine.

2.3.1 Historical road to dichotomy and marginalization. Records from the thirteenth-century in Gnostic philosophy and Christianity show that people engaged in self-starvation for “sacredness,” “purification,” and “penance” (Witztum, Stein, Latzer, & Kalian, 2016, p. 170). Though there are records that Christian male monks engaged in voluntary fasting, most records report women, specifically young women, starving themselves for religious and spiritual beliefs (Pini et al., 2016; Witztum et al., 2016). Meanwhile, records exist of men aspiring to have the physique of their gods at the time (Pope, Olivardia, & Phillips, 2000). In their seminal book, *The Adonis Complex: The Secret Crises of Male Body Obsession*, Pope, Olivardia, and Phillips (2000) used the Greek mythological god Adonis to characterize males with body-distortion issues and eating disorders. According to historians, Adonis’s body was representative of the ultimate in male physique. The Middle Age’s dichotomy of female starvation for spiritual purity and the male ideal of physique still persists today.

It was in the 1970s that anorexia and bulimia studies proliferated, beginning with psychiatrist Hilde Bruch’s (1973) *Eating Disorders: Obesity, Anorexia Nervosa, and the Person Within*, which contained observations of her previous years’ work. Bruch specifically began case studies with young, white, middle-upper-class women. Only women were studied because at the time the medicalization of eating disorders occurred through a patriarchal and male-gendered lens. In 1873, physicians Ernest-Charles Lasègue and William Gull had offered a medical description of anorexia, but Lasègue first used the term *anorexia hystérique* to denote the hysteria of a woman’s starvation (Moncrieff-Boyd, 2016; Niedzielski, Kaźmierczak, & Grzybowski, 2016). This hysteria meant women were seen as “lacking an autonomous sense of self and a continued obedience to parental figures, leading to an inability to master...psychological tasks” (Pini et al., 2016, p.1655). Bruch and other

researchers aimed to help women regain weight as well as increase insight into therapy modalities needed to treat comorbid mental health issues such as, depression, anxiety, and the abandoned—yet still present from a medical lens—term, hysteria (Bordo, 2009; Pini et al., 2016). This research ethos highlights the medical history of pathologizing the female experience of an eating disorder.

This ideology is a contributor to missing data on men because men did not prescribe to the gendered notions of eating disorders as a woman's issue (Mitchison and Mond, 2015). As a result of this female-centric yet patriarchal history, male experiences of an eating disorder are missing from the landscape. They are missing because of stigma and the gendered notion of what it means to be a man (Mitchison & Mond, 2015; Räisänen & Hunt, 2014). There is increasing research being conducted regarding the absence of men with eating disorders in research and treatment, albeit still marginal compared to studies of females.

To explore the missing male experience in research and treatment, I conducted a literature review using the keywords: “eating disorders,” “eating disorders + male/men,” “autoethnography,” “anorexia,” “muscle dysmorphia,” and “orthorexia.” To expand on common themes found in these searches, I reviewed additional literature on patient voice in mental health.

2.3.2 General scope of marginalization.

Several scholars have conducted qualitative studies using an interpretative approach to gain an understanding of the male experience of an eating disorder (Bunnell, 2015; Mitchison & Mond, 2015; Pettersen et al., 2016; Räisänen & Hunt, 2014; Reas & Stedal, 2015; Robinson et al., 2012; Strother et al., 2012). These studies concluded that barriers to help,

such as stigma and female-centric services, are issues that men face when receiving eating disorder treatment.

2.3.3 Female-centric and gender. Räisänen and Hunt (2014) provided context for understanding how treatment providers and their clients experience gender as a barrier to proper treatment. These researchers conducted interviews with men who reported information given by medical professionals was gendered. Räisänen and Hunt (2014) also identified clients themselves as barriers to their own care. For example, one participant stated he was, “one of the lads’ in the rugby team and not someone who could have a problem with eating” (p. 3). The researchers identified men who “did not come to consider the possibility of having an ED because of the inappropriateness of an ED as a socially available explanation for them as men (p.6).

This gendered look at eating disorders is also echoed in Strother et al. (2012) and Pini et al. (2016). Strother et al. (2012), argued,

there is evidence that men with “undifferentiated” and “feminine” gender roles have a higher prevalence of disordered eating than men with “masculine” and “androgynous” roles. Therefore, it is recommended that professionals involved with treating disordered eating be aware of the influence of gender roles and gender differences in determining the presence or absence of disordered eating. (p. 349)

This highlights stereotypes as a problem in eating disorder treatment because treatment misses the diversity of male experiences. Lavender, Brown, & Murray (2017) noted that research on or with men with eating disorders “has increasingly focused on muscularity-oriented body image and disordered eating, characterizing the unique behavioral patterns (e.g., cyclical restriction and bulking) associated with pursuit of the muscular ideal” (p. 5). This false stereotype that all men want to be muscular does little for those who do not identify as muscle-men or any physical male archetype and is especially problematic for people who are transgender, or agender, or bigender, or non-binary (Bowmen, 2018; Diemer, et al., 2018;

Gordon et al., 2016). By using gender stereotypes to fill in the missing male experience, a much richer and diverse voice is lost. To gain what is lost, caution is warranted against oversimplifying a male homogeneous experience as a call to include variety. As the next collection of research will attest, doing so may lead to stereotyping and stigma.

2.3.4 Stigma and stereotype. Strother et al. (2012) presented a tidy summation of the relationship between stigmas and men and eating disorders. At the conclusion of their research they argued that the

encouragement of a culture which allows for male vulnerability is a major goal. Men are not supposed to be emotionally vulnerable in our present culture... This is deleterious for many men as they feel pressure from many sources to meet mainstream society's definition of masculine. Also, men are not supposed to be focused on how they look, so why would they reveal body image or weight concerns? This is a major hurdle for the advancement and better understanding of men with eating disorders. (p. 353)

Here the entangled issues of stigma and gender are evident. Räisänen and Hunt (2014) reported that one man they interviewed was told by his doctor to “man up, be strong ,and deal with the problem.” (p. 5). This reaction creates a cyclic effect: no professional space or social space exists that permits a man to speak without sacrificing “maleness”: therefore, men do not speak. Having no voice in the arena creates an outlook that a man should not have an eating disorder: therefore, a man does not talk about his eating disorder. Ergo, no space creates no voice; no voice creates no space. The stereotype of a man creates the stigma of not being a man. Arguably, this is not misogynistic; it is not about being female or male; rather, it is about not being reduced to stereotypes of gender. Bordo (2009), Easter (2012), and Griffiths et al. (2016) pointed out that females also feel stigmatized because of gender stereotypes. Bordo (2009) noted that eating disorders are seen as a “privileged...white girl” issue, and many women do not subscribe to that stereotype (p. 47). Easter (2012) reported that females felt personal responsibility, self-blame, and guilt for an eating disorder because it is still seen

as a choice by some, implying that those with eating disorders have low self-esteem and an unhealthy self-efficacy. Griffiths et al. (2016) noted that “the perceptions that people with eating disorders are attention seekers who are personally responsible for their condition and who have only themselves to blame for their predicament” (p. 279) also creates stigma. In addition, both men and women felt that the mental illness of an eating disorder comes with stigma. The above research results make clear that stigma is embedded in the diagnosis and accompanies it: the diagnosis includes an inherent stigmatization (Griffiths et al., 2015; Pettersen et al., 2016; Räisänen & Hunt, 2014).

2.3.5 Poor health outcomes. Gendered treatment and stigma correlate with poor health outcomes. Pettersen et al. (2016) argued that the consequences of marginalization are an “increased risk of a slower recovery process ... thereby prolonging the duration of illness and raising the probability of a poorer prognosis” (p. 1). While males represent 25% of those with anorexia and bulimia, they are at higher risk of dying because both men with eating disorders and healthcare professions assume males do not have eating disorders (Mitchison & Mond, 2015; Strother et al., 2012). These statistics vary only slightly from research conducted in the United States, United Kingdom, Australia, and Germany (Mitchison & Mond, 2015).

Wong, Ho, Wang, and Miller’s (2017) research paper, “Meta-Analyses of the Relationship Between Conformity to Masculine Norms and Mental Health-Related Outcomes,” concluded that conformity to masculine norms was “unfavourably associated with mental health as well as moderately and unfavorably related to psychological help-seeking” (p. 80). By the end of their study, the scholars suggested that “clinicians should guard against pathologizing individuals (pp. 89–90). Feminist discourse that critiques societal expectations also shed light on the shaming of men for not submitting to gender stereotypes.

A decade earlier than Wong et. al, Clare's (1998) research found that men often were confronted with both power and masculinity entwined when they sought treatment for cancer. When interviewing men who had undergone cancer treatment, she spoke to a specific case in highlighting what she discovered:

[the patient's] pride prevented him from asking for help, but it was not offered to him—perhaps because of his façade of control and stoicism, and the doctors' expectation that men behave like this, even in the face of overwhelming threat. This is the cost of the heavy burden of maintaining what we have been led to believe is “the making of a man.” (p. 1074)

Here it is evident that men are being silenced by their own dominant myth—that to be a man is to be strong in the body and silent in words.

2.3.6 Client voice and stereotype. According to Pettersen et al. (2016) and Räisänen and Hunt (2014), gender stereotypes prevent men from being seen or heard as a full person. This is to say, because of client stereotypes that see them as unknowledgeable about eating disorders, men are still not listened to as a whole person (Strother et al., 2012). This client stereotype does not apply to males only. In her autoethnographic research, Applequist (2014) offered her journal entries to highlight “what it feels like to receive the label of an eating-disordered patient” (p. 119). In one of her entries she writes,

I'll never get discharged from this place. I'm so tired of hearing “we know what we're doing. You're driven, Janelle, but is this you or your eating disorder talking?” It's me. Just because I have an eating disorder doesn't mean I'm lost forever. I'm still here. (p. 121)

This sentiment is echoed in females who ask for “treatment that focuses on them as a ‘whole person’” (Rance, Moller, & Clarke, 2015, p. 587). To focus on the whole person is to consider Saukko's (2006) point that “research on eating disorders is often grounded in a dichotomous way of conceptualizing their personal implications... such as dominance versus freedom. This type of reasoning mimics and fuels anorexic thinking in terms of one-dimensional absolutes”

(p. 2). What emerges from this research is that being stereotyped as a client means being labelled according to a generalized assumption of “being anorexic” or “being bulimic.” These statements demonstrate that medical models of eating disorders tend to label the client as the condition, reducing them to the “problem.” To mitigate this reduction, Pettersen et al. (2016) suggested that “factors relevant to recovery appear to be the importance of feeling understood, listened to, and cared for in treatment or in support groups” (p. 2).

2.3.7 Client voice heard. In counselling psychology an abundant amount of literature supports listening to the client and positioning them as the expert on their experience (Jones-Smith, 2014; Sweeney et al., 2019). Presumably, this privileging minimizes stereotyping by positioning the client as person rather than as condition. Doing this may help prevent a client from being reduced to a stereotype and allow for the individual to be respected as a knowledgeable agent in their own positive health outcome (Gillard et al., 2015).

Carl Rogers’s (1995) claim that “we cannot change, we cannot move away from what we are, until we thoroughly accept what we are. Then change seems to come about almost unnoticed” (p. 17) lies at the centre of client-centred approaches to therapy. When a counselling therapist listens to all of who someone is rather than a stereotype, a client can begin to move away from a position of deficit into a role of being a self-determined agent for their own change. Gillard et al. (2015) suggested that co-operation and the therapeutic alliance are important factors that can determine whether clients have positive “experiences that are empowering, facilitate change and promote agency and hope” (p. 13). Egan and Reese (2018) and Sweeney et al. (2019) also suggested counselling psychologists practise the art of listening to and affirming a client’s perspective and experience in order to foster positive health outcomes such as “being able to control and manage feelings and thoughts,

and becoming more self-confident, self-assured and positive” (Gillard et al., 2015, p. 9).

Given the evidence above, it is safe to assume that silence is not optimal for mental health or for those with eating disorders. In light of this, it is time to speak.

2.3.8 Male media and website platforms. Certain social media and websites place a male image on their platform. For example, on Canada’s National Eating Disorder Information Centre (NEDIC) Facebook page is an image with text saying, “Eating disorders are as diverse as the people they affect” (Figure 2.3 below, bottom right). Figure 2.4 is an enlarged version of one picture in Figure 2.3.

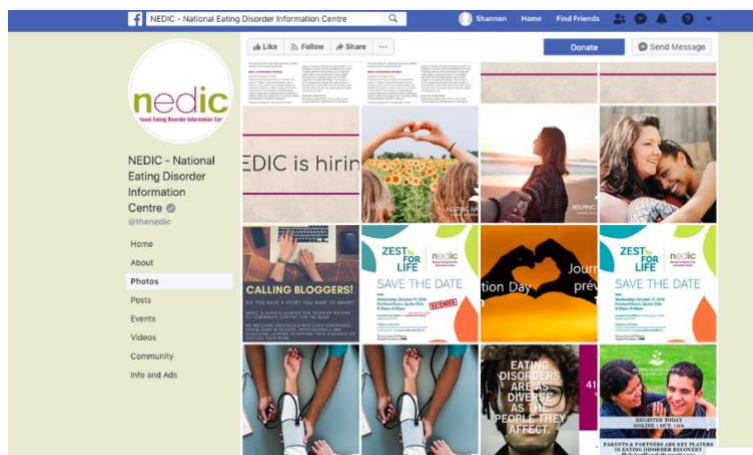


Figure 2.3. NEDIC Facebook page. Screenshot of NEDIC Facebook group page [Facebook group page], by National Eating Disorder Centre [NEDIC], n.d. (https://www.facebook.com/pg/thenedic/photos/?ref=page_internal). Reprinted with permission from the NEDIC Team.



Figure 2.4. Enlargement of photo of NEDIC Facebook page. Screenshot of NEDIC Facebook group page [Facebook group page], by National Eating Disorder Centre [NEDIC], n.d. (https://www.facebook.com/pg/thenedic/photos/?ref=page_internal). Reprinted with permission from the NEDIC Team.

Figure 2.5 (below) is a screen shot from NEDIC's Instagram account. Here one can find men in the upper middle image.



Figure 2.5. NEDIC: Instagram with men. Screenshot of National Eating Disorder Information Centre Instagram Page [Instagram photograph], by NEDIC [@the-nedic], March, 12, 2018 (https://www.instagram.com/the_nedic/). Reprinted with permission from the NEDIC Team

It is not uncommon for eating disorder websites to have information about men as a separate link from the main page. This suggests that there are eating disorders, and then there are eating disorders for men. For example, Figure 2.6 (below) is the home page from the National Eating Disorders Association in the United States. One can find information about men by following a link (see Figure 2.7). There is information about men; however, that information is not visible from any website's main page that this study's search found.



Figure 2.6. NEDA website main page . Screenshot of [NEDA home page], by National Eating Disorders Association, January 20, 2019 (<https://www.nationaleatingdisorders.org>). Copyright 2018. Reprinted with permission of NEDA.

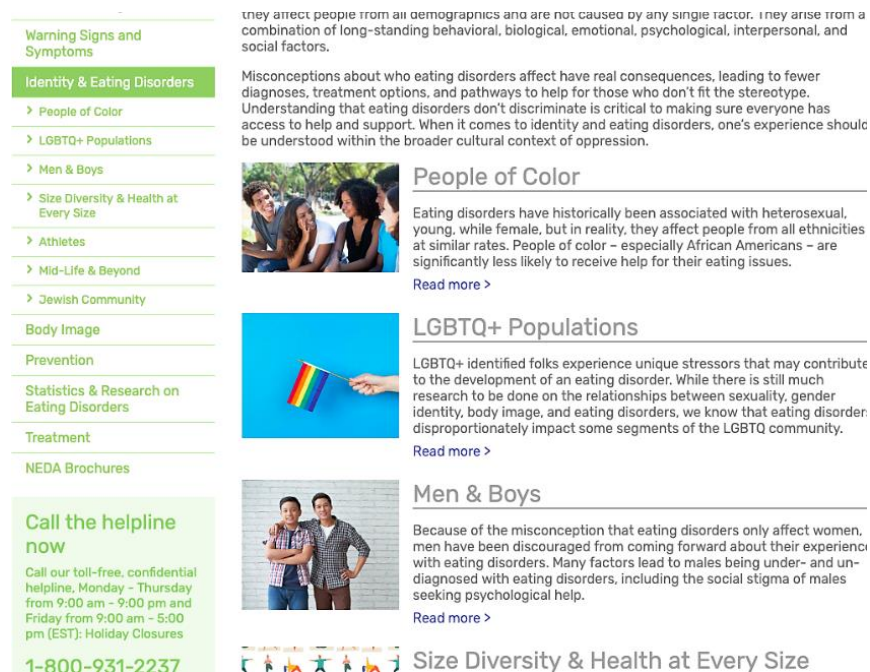


Figure 2.7. Finding the link. Screenshot of [identity – eating-disorders], by National Eating Disorders Association, January 20, 2019 (<https://www.nationaleatingdisorders.org/identity-eating-disorders>). Copyright 2018. Reprinted with permission from NEDA.

The same can be found on United Kingdom websites. As of January 2019, the first two pages of results of a Google search using the phrase “men with eating disorders” produced twenty websites. One website displayed men on the main page: a men-specific eating disorder website (<https://namedinc.org/>). Another was a young men’s health website with links to information about eating disorders (<https://youngmenshealthsite.org/>). A Google search using “transgender eating disorder” yielded no trans-focused websites, only personal blogs. Perhaps the above information about websites and social media is anecdotal evidence; however, as illustrated in “Literature Lived”, these buried male images are relevant to consider when acknowledging the limited space in which men are seen in the eating disorder landscape. It is clear that diversity is recognized, but it must be deliberately sought by the viewer. Apropos, both literature reviews describe gender stereotype, stigma and an artificial client identity as influences that speak to the marginalization of men in eating disorder research and treatment.

Chapter Three

Methods

3.1 My Story – Try Not to Cry

“Try not to almost cry this time. It’s not a goddamn counselling session.”

I would think this to myself as I went for a meeting with my thesis supervisors. Never because of looming deadlines or fear of massive rewrites (though those things exist), but because of my relationship with this word—responsibility.

Leah leaned in from her chair, her elbow on her knee, chin on her palm, and fingers curled. She was listening. Slightly rocking and listening. Sarah sat on the floor, with me, listening to me as well. I was lost in a sea of drawings, poems, and stacks of scribbles. I would fight back tears seeing this evidence, experiencing evidence, knowing, experiencing deeply all the confirmation of hurt. And knowing full well my hurt is shared by others in the offices, rehearsal halls, and on the streets.

“But what do I know?”

“Who am I to say this?”

And Leah and Sarah were where I was, in the mess with me, with genuine curiosity and kindness. They were right there with me, and we unpacked my questions, and they helped me face the fear of what I know.

I was intimidated that I knew the status quo for eating disorders must change. I’ve met men who were not seeking help because there was no place for them to get help. Men I’ve been on bike rides with, been in staff rooms with, sat on planes with. I was angry that nothing is done. I was also haunted by the faces of those professionals who are in a position to do something. The people like Donna who are trying their best at what they do. And I know the

knot in my stomach from this—from the unbridged gap between those who need help and those who can help. The knot in my stomach from my muscle contracting with feeling scared, hurt, and vulnerable. And for feeling compassion for both sides—those who need help and those trying to help.

Why can't we just all join hands and sing "Kumbaya" in the park?

I'm naive.

I'm angry.

I'm sad.

I'm intimidated by the mix of it all.

Okay, I say to Sarah and Leah, I'll become a researcher and tell this story.

3.2 Methods Overview

The above narrative illustrates the epistemological underpinning of this thesis by showcasing that knowledge is co-created and that multiple voices hold multiple perspectives. *Constructivism* is a philosophical position that recognizes that "views, values, beliefs, and feelings" can be places of knowledge (Creswell, 2014, p. 432). I embrace this perspective and recognize that my methodology was to investigate my feelings and understand them in relation to the climate in which they exist. The purpose of this study is to investigate their origins in the past as a male client and in their present moment as a graduate researcher.

Qualitative research is used to understand how people construct their worlds, interpret their experiences, and make meaning of their experiences (Merriam & Tisdell, 2016). As a tenant of qualitative research, autoethnographic researchers seek to "retroactively and selectively [write] about past experiences" (Ellis, Adams, & Bochner, 2011, para. 5).

This thesis is built from reflective memory. First, to investigate whether my feelings were “just me or what?” I did a literature review to ascertain if other men were experiencing the same issues of marginalization, stigma, gender, and stereotype. Next, I went through my journals from 2005 to 2016 and looked for themes. I re-read my diaries, scribbles, pictures, comics, and poems and looked for issues paralleled in the literature review. Ellis (2004) suggested that researchers “decide which events are critical and describe them in a way that ‘expands the moment’” (p.366). I write about the experiences I had to further unpack the aforementioned themes with an insider/outsider voice embedded in qualitative narrative research.

Whenever I am asked about eating disorders, I find myself holding back my true feelings and opinions as to not emotionally vomit on the inquirer. Writing an autoethnographic thesis is transforming the vomit into learning opportunities.

I did not want to get my emotional vomit all over Donna or the doctors, psychologists or counsellors in the upcoming stories. At the kitchen table or university library desk, I can focus my emotions into palatable words; however, this process comes with pressure. Ellis and Bochner (2006) argued that the point to autoethnographic writing is that it should be evocative. Therefore, renovating my emotions is to perform an “autopsy” on the story after it is told. This, Ellis and Bochner contended, is to privilege analysis over story and assume the “the story is merely data to be analyzed” (p. 444). They concluded that “analysis and story also can work together. There’s no reason to preclude adding traditional analysis to what we do, as long as it’s not treated as necessary to legitimize our stories” (p. 444). Yet, I do so to articulate the “ethno” tenet of this research: I use analysis to extend a discovery I had telling a particular story as research into an inquiry about eating disorder discourse more broadly.

3.3 My Voice(s)

Despite Ellis and Bochner's (2006) advice, I perform an autopsy and present story and analysis sometimes separately. I do this to help navigate multiple identities I hold: storyteller, client, researcher, male, and new counsellor. I hold a majority of privileged positions—being male, white, a middle-income earner, heterosexual—yet I am a minority in the eating disorder landscape. I am also a counsellor and a client. I am simultaneously the researcher and a subject. I am what Walker (1997) called *inhabiting the slash*.

Walker (1997) characterized the phenomenon of inhabiting the slash in the context of clinical nurses inhabiting the blurred lines between theory and practice as well as blurred lines between their personal and professional life (p. 4). Ruth Surtees, a nurse in an eating disorder unit, wrote that she was slim and had to model “normal” (she used these quotation marks) in the eating disorder unit. Sometimes Ruth was not hungry at exactly 12 noon, but “Nurse Ruth” had to eat slowly in front of others to model “normal” eating and to display that her slim figure was her healthy weight (Surtees, 2009). Surtees proposed that inhabiting the slash “contributed to a degree of critical purchase [she] would not have gained otherwise” (2003, p. 10).

My inhabiting the slash allows for the same active investigation in eating disorder research. Inhabiting the slash means exploring the relationship between my privilege/oppressed position when inhabiting my slashed male/client/counsellor/researcher body. I am a high-school guidance counsellor: I know what it is like to have my best intentions on the line every hour I work and be unpolished, mess up and not get things right. I am a client: I know what it is like to have even these best intentions make an unintended impact that hurts. I am a researcher: I know what it is like to care for, with fidelity, respect,

and responsibility, the people who are in my study. I am an autoethnographic researcher: I know what it is like to have these positions and identities interact and play out on paper in a thesis.

In light of inhabiting the slash, my voice can only speak to my experience and not that of other males, or counsellors, or eating disorder clients. Ellis (2004) asked if it is fair for autoethnographic researchers to expect an individual's story to represent the story of a group. Contending with this issue, Ellis wrote that autoethnography “should try not to speak ‘for a community’ but instead should be engaged in shared conversations in which they speak ‘to and with the community,’” adding that “personal narratives [don’t] skirt representation issues; it complicates them.” (pp. 207–208).

While acknowledging this intersectionality and the insights inhabiting the slash bring, I write my personal story *and* an analysis in an effort to uncomplicate the complicated. However, there are times when I use both researcher and client voice within one setting. In some sections I write prose and dialogue between myself, Dr. Sarah Pickett, and Dr. Leah Lewis, my thesis supervisors. I do this to highlight the process of becoming a researcher. Ellis (2004) noted that autoethnographic research emphasizes writing as a process of discovery. My process of discovery meant shifting from a voiceless client in my diaries to an assertive voice as a researcher. My dialogue with Dr. Pickett and Dr. Lewis highlights this process.

Consideration is given not to leverage the silence in my stories for empathy and sympathy. Critics of autoethnography caution against naval gazing and being self-absorbed (Ellis, Adam, & Bochner, 2010). While my aim to be evocative is to better situate the reader inside my experience, I also am sure to expand my experience beyond myself. The literature reviewed and analysis after my story help to move what is personal into what is cultural. The

subsequent analyses also mitigate the potential for autoethnographic inquiry of the self to be public therapy. Ellis, Adam, and Bochner, (2010) suggest that autoethnography writing can be therapeutic. While I agree that this thesis is therapeutic, it is not therapy; although, I found agency in my lived experience I may not have gained otherwise. It is not for the sake of divulging sadness onto the page in an attempt for a pat on the back. Rather, by telling my story, I hope to underline the importance of understanding the silence and diversifying what is heard and affirmed in eating disorder research and treatment.

3.4 Speaking My Voice

In addition to following the works of Caroline Ellis and Arthur Bochner to craft my research, I simultaneously follow the fundamental ideas of *narrative therapy*, which proposes that the externalization of a problem will allow the problem to become the problem and therefore not conflate the person as the problem (White, 2007). Once the problem is externalized, it is even more possible for people to assume responsibility. On the other hand, if people see themselves as the problem, they may become self-destructive (White, 2007).

In counselling therapy, an individual with an eating disorder is often told by the therapist that the client's eating disorder is talking when a client seems "resistant" to any aspect of treatment. "The eating disorder is talking" is offered by the therapist in place of unpacking and understanding the client's perspective on why they have articulated a thought (Applequist, 2014). For example, I was given a family-therapy book to read by a counsellor. I read it. It was written for parents about how to deal with their child who has anorexia. In the next session, as the counsellor reached back for another book, I told the counsellor the first book was not a good fit for me because I was 28. I was neither a father to a child nor did I live with my Mom and Dad. The counsellor told me my resistance was my eating disorder talking,

giving resistance to treatment. The counsellor was the expert so I thought, “I’m resisting. I need to listen. My fault.” Through this autoethnographic journey, my voice has been externalized, and I know my responsibility lies not in faulting myself for the past but instead in bringing those experiences to light to help eating disorder researchers and helpers contextualize their role and responsibility.

Wallis, Burns, & Capdevila (2010) wrote that narrative therapy centres people as the expert on their lives and assumes that they are competent and capable of reducing the influence of problems in their lives. An examination of my experiences shifted my voice from an apologetic client to an expert researcher. I no longer dismissed my feelings of reduction and emptiness as faults of my own but as data to understand the culture in which those feelings sat. Layering the process of narrative therapy also illustrates the epistemological paradigm through which I research. Narrative therapy is also a post-structuralist model, which in and of itself critiques absolutist models that tend to define the patient by their condition. This research is carried out through a constructivist lens, which presupposes that knowledge is constructed and co-constructed through perception and experience (Mcphail, 2015).

White (2007) proposed one type of inquiry in narrative therapy called “Negotiating a Particular, Experience Near Definition of the Problem.” My near-experience definition of the problem as a client deeply informs my responsibility as a researcher and a counsellor. It informs me as a researcher that we have a responsibility to listen to the silence. This thesis is a response to an eating disorder landscape that created the silence. This study is evocative and analytical in laying a blueprint for agency on behalf of researchers and counselling therapists.

3.5 Ethics

There are ethical considerations that guide writing autoethnography. The stories that follow are about me, and they are about others. They are about people in my past who are (now) unwitting participants in research. My research is not focused on the helper's perspectives on working with people with eating disorders; rather, the focus of my research is the client perspective: the inner impact, thoughts and feelings of the client in treatment. Yet, even though the focus of my thesis is on me and my experience, "when we write about ourselves, we also write about others" (Ellis, 2007); hence, I cannot write about my experience without including others.

The works of other autoethnographers offer cautions and suggestions for how to write about others. Ellis (2007) wrote that this kind of research is "not necessarily research for others—it's their lives. [We] should make sure we're being sensitive to other people." (p. 305). I struggle with the word "sensitive." For me, becoming a researcher began with an apologetic voice, one that said "sorry" after every sentence. I wrote about the impact of a helper's action. I asked myself if I was being sensitive to my experience as a client. I wondered if I was again muting my emotions and discounting my feelings. In writing this thesis, I have been sensitive to both sides of the conversation, the helpers and the client. As time went on, I learned that my experiences positioned my voice as one of an expert. Not an expert on the life of the other person in my story but rather the expert on my thoughts, feelings, and actions. Ellis (2004) also wrote that autoethnography "critiques the institutions that determine identity and how we value or devalue certain identities." (p.325). Therefore, the word "sensitivity" extends not only to the others in my stories but also to the telling of the story itself—that is, the cultural phenomenon and myself in it—and not the other person.

When writing my story and involving other people, I also strive not to reduce, caricature, or assume an identity of others in my story. I mitigate potential stereotypes by first following Ellis's (2007) advice to "omit things, use pseudonyms or composite characters, alter the plot or scene" (p. 24) in order to show the scene and my relationship to it rather than the other person in the scene. In other words, the focus is on my experience; therefore, changing names and places keeps the ethos of the scene intact while also protecting others. Ellis (2007) also asked, "How do we honor our relational responsibilities yet present our lives in a complex and truthful way for readers?" (p.14), then wrote, "think it through, improvise, write and rewrite, anticipate, and feel its consequences. There is no one set of rules to follow" (pp. 22–23). Therefore, following the advice of Ellis, my ethical behavior involved constantly checking with supervisors, critically reading other autoethnographic researchers' ethical considerations, rewriting, focusing on my experience and the context in which my experience sat, consulting, and once more rewriting.

I also chose not to interview past counselling therapists because to do so would have dissolved past confidential client/therapist relationships into new working researcher/subject relationships. Reopening, engaging in, and redefining past therapeutic relationships is also beyond the ethics and integrity of what I need as a researcher. In addition, this would have expanded the project to include the experience of the helper, thus moving the focus away from the client experience. To parallel the client and counsellor experiences is a worthy endeavour; however, it is beyond the scope of this study.

As part of a lecture in the Henry Kreisel Lecture Series, Michael Crummey described an author's dilemma when writing historical fiction, asking, "Am I appropriating their side of the story to advance my side of the story? What are the limits of the liberties taken when I tell

my side? Am I using the defenceless to tell my story? What is my fidelity to history?” (Redel, 2018, 44:00min). Though I am not writing historical fiction, I have asked myself these same questions because I am putting up the fourth wall to allow myself to speak my side of the story. The ethics of this —speaking my side of an event, getting out of me what experiences are in me—comes with its own potential hypocrisy to contend with. I ask for open dialogue between myself and my past counsellors, yet I am the sole author of this thesis. When I ask myself Crummey’s question—What is my fidelity to history?—I answer that I have fidelity to let the past marginalized voice become public in the present. This thesis is the second part of the conversations I wish I had had with those in my stories; therefore, the story of clinician and client is told in equal parts. People in my stories are not defenceless because they are not under attack. By telling my side of a story I am not shouting down, I am searching for equality.

3.6 Limitations

Creswell (2015) suggested that

critical researchers position themselves in the text to be reflexive and self-aware of their role and to be upfront in the written research report. This means identifying biases and values, acknowledging views, and distinguishing among textual representations by the author, the participants, and the reader. (p. 471).

I acknowledge that I may have a bias of *reality apathy*. This is an occurrence coined by Aviv Ovadya whereby chronic contact with misinformation makes people stop trusting what they see and hear (Gilpin, 2018). It is arguable that reality apathy may taint the colours through which I encounter eating disorder treatment. In other words, it is conceivable I see everything in relation to eating disorders through a pessimistic lens because of adverse moments in the past 20 years. To be certain apathy remains at a distance I have reminded myself of the healthy counselling I’ve received and feminist eating disorder research that

spoke to me. I have reminded myself of the medical doctors, psychologists, social workers, and dietitians, either male, female, transgender, or non-binary, who have been a tremendous help.

I am reminded of their healing relationships with me. I remember they acknowledged the “slashes,” and we gave them roles in our work. In one relationship with a social worker, we explored how my personal life’s wonder and curiosity and desire to share could translate into professional work, and I became a counsellor. I had a psychologist and a medical doctor ask how my client experience might be shared and benefit others, and I became an academic researcher. The relentless love and optimism I have for the present and future of eating disorder research and treatment remains steadfast.

Chapter Four

Missed Moments Become Outcomes

The following four stories are explorations of the previously named themes in my literature review: Theme 1 is not having the space to be heard at all. Theme 2 is being reduced to gender, and Theme 3 is having my gender stereotyped. Apropos, these reductions in identity also reduce my client voice as possessing knowledge of my own experience and as expert in my own agency for change. Rather than an alliance with the helper, I felt tension between my desire to be heard and their voice of professional knowledge. The consequence was that it was often difficult for me to build agency within myself for change.

4.1 My Story – My Turn to Help! (Nope. Not Yet.): No Space

“Yes, my turn to help!”

When I saw that poster for a body-positivity workshop, I was ecstatic because I thought my personal life and emerging professional life were coming together in a beautiful, symbiotic way.

I’d been 20 years with an eating disorder and had been a part of wonderful therapeutic relationships. Social workers, psychologists, nurses, all helped me along a journey in changing my life. This in turn, informed my decision to become a counsellor. When I saw that poster, I was a counselling psychology student. This workshop was an opportunity to pay it forward to others in a specific way.

I remember countless moments during times together, both with therapists and with my friends, that I had this blissful, joyful feeling of wanting to share deep connections with others. Even as I write this now, I’m flooded with rich, thick love. I can think of the best music I love, I crank that up and dance with it with my closest friends. That’s the feeling. And

back then, with those feelings, I thought, someday, somehow, I want this feeling of connected creativity to be what I do from nine to five. Connection matters in my personal life; imagine what it would be like to have this in my professional life so that I wouldn't have to abandon that connectivity to do other things.

My turn to contribute and pass it forward! Can't wait!

And then.

And then I went to the workshop. We were sat in a fish bowl. We trainees sat on the inside circle, and the presenters and trainers sat on the outside. And were handed scripts. The workshop was a company giving us a script and telling us what to say in order to tell women what to think. The creators of the workshop touted cognitive dissonance as the best cure for believing in magazines because they believed slick advertising places people at high risk of eating... "pathology." I place "pathology" in quotation marks because we were instructed not to say "eating disorders." The workshop was not about individual counselling or group therapy; it was about dissonance induction; it was about not thinking. It was about telling teenage girls not to think. The script didn't have the curiosity or vulnerability I was expecting. There was no growing or building. There was only prescription and dictation—not what I was expecting. But it was researched and created by people with PhDs, so I sat in.

The owner of the script sat on the outside of the circle and reminded us of the pacing of the script.

"Don't spend too long on this bit."

"Make sure to say these words and not those."

I thought that because we had at least 20 people in the room we'd have an opportunity to collaborate on each other's experiences. But I said nothing because of those on the outer-

fishbowl's commitment to the economy of it all. They were timing the script to keep it on pace. I didn't speak my thoughts until one time.

I voiced my concern about a homework piece.

The homework was to get a commitment from the participants in future workshops to go home in front of a mirror and list their positive attributes.

"What if we give the homework as a soft suggestion?" I asked.

"No," The therapist and facilitator in the corner said, "We need a vocal, in-the-circle, out-loud-to-everyone, commitment from them. My experience is, without accountability, they won't do it."

"Okay," I said.

I'd rather it be a soft suggestion, but what I do know?

I had an internal tension between my counselling therapist's voice and my voice as someone with an eating disorder.

As a graduate counselling-therapist student, I understand the importance of language in group facilitation, that the leader provides a buy-in for the group. I've read Samuel Gladding's textbooks and Irvin Yalom's books on group therapy. I know the potential of homework to become empowering assignments that can help clients practise or refine skills (Gladding, 2018). I know that Yalom and Lescz (2005) wrote about group cohesiveness, that a sense of belonging can be a powerful feeling that one has meaning in relationships. A group commitment to homework can bring about group cohesiveness.

But more important in this particular moment than my thoughts of being a counsellor were my feelings of being a client.

I thought the homework was a terrible idea because I had had to do something similar.

When I first started working with Laura, a social worker, I could not list one kind thing about myself. Not one. And it was crippling. In our second session, I remember staring at a piece of paper with a big, ugly, empty circle with nothing in it. I was supposed to write something, something kind about myself, and I could not write anything, nothing at all. Emptiness surrounded me when I first stared the cold, lifeless circle. It haunted me; I felt alone, and it sucked.

Yet, I was not alone, and it didn't suck for long. Laura was there, and with her help, we filled that circle. Over the following weeks that turned to months, we filled it with colour and emotions and life. In fact, we broke the lines of the circle to expand into all areas for my life, beyond me; we discovered and created love and kindness and beauty everywhere.

But back to the mirror homework for the workshop. I imagined someone who had been to our body-positivity workshop that day, standing in front of a blank mirror as we had asked them to do. "What if someone at the workshop was me?" I thought. Looking into emptiness with nothing kind to say about themselves and we sent them home alone to stare at nothingness. I imagined the next day that person would come back to our workshop with no counsellor, no professionals to help, just a bunch of young script readers there to fire off the next round of timed paragraphs. The person we gave the homework to sat there and expected to report what they had felt the night before. I had Laura in a safe environment. This person in the chair, who was in front of the mirror, who did they have? What responsibility did we have as facilitators to deal with this vulnerability? How lonely would it be to stare into an emptiness without a safety net around and walk back the next day with no one to listen?

"What if we give the homework as a soft suggestion?" I asked.

"No," The therapist said.

I felt responsible to who might be looking at the mirror that night because of my own client experience of also looking in the mirror. As a facilitator in the group, I also felt accountable for the participants the next day who may have experienced what I did looking in the mirror.

To be clear, the intention of the therapist was not to devalue my experience. I wasn't asked for my experience because the workshop was about disseminating the script and not learning from the participants.

Still, “No,” the therapist said.

My mind and body were now staring at the blank circle from years back and at the empty mirror of what might happen to those girls we would send home. To bring my body back to the workshop, I turned my emotions off. I calmed my insides down, stopped myself from shaking, and the warmth went back into the cold, clammy hands—because that question “What if we give the homework a soft suggestion?” was me trying to speak.

To bring my body and brain back to the workshop—to “get-on-with-it.”—I switched from empathy to logic and thought. This hypothetical person alone in front of the mirror who needs help, maybe I’m just making this person up. Maybe I shouldn’t be so attentive to imagined things. And besides, the psychologist didn't know of my history because I didn’t speak of it because that weekend wasn’t the space for it and that’s okay. It’s like bringing a soccer ball to a hockey game. My mistake, the wrong venue to want to interrupt with my experience. What do I know of it all anyway?

My turn to help.

Nope.

Not yet.

4.2 No Place

In the above story, I illustrate the opportunity missed when people speak without intent to listen and without making space to listen.

I don't fault the therapist for not knowing my experience because that workshop was not a space for sharing my experience. But the problem is neither were a lot of other spaces. The economy at which therapy sessions are 45 minutes long, insurance covers four to six sessions, or weekend workshops happen for only a few hours, or doctor visit times are short, means the necessary listening cannot be done—for what if someone was to speak?

4.3 My Story – Blind Spots: Seen but Not Listened To

We were seven sessions in. She leaned back in her chair as she re-crossed her legs; her arm moved from her lap and draped over the back of the chair. She was about to inform me of my *blind spot*, as they call it in counselling: the moment her detective work had uncovered what was holding me back. She appeared confident about her insight as she began explaining to me the linchpin of my problems:

“Shannon, are you hiding from responsibility?” the social worker asked. “You seem to be wary of being put in a box and categorized by institutions. But who's really saying no to you and putting you in a box? I've had other clients, young girls with eating disorders, who want to keep small to retain their adolescence. In essence, they want to shrink away from being an adult. By staying small, they can hide away and not be seen in the room. I wonder if you are doing the same. Have you ever challenged those who seem to say no to you?”

I don't remember what I answered.

I do remember that it took me awhile to get something out.

Something polite.

Being a client is hard, not because having an eating disorder is hard (it is), but because I find it difficult to be polite to the person across from me when they are not listening.

Seven sessions in, and she had not listened.

I was not—and still am not—an adolescent girl.

Nor did I want to—and still do not want to—shrink from anything.

My mind and body never shrank from responsibility; rather, it grew—grew tired of it, was rubbed raw and ached from responsibility. If she had been listening, she would have known of the insurmountable responsibility I had given myself to fit my body into the roles I sought, whether it be a bulking man in the gym or a slender triathlete on the podium. My body morphed depending on what group I wanted to belong to, and that responsibility had taken its toll on me. My eyes were sunken not from a shrinking body but from the relentless responsibility I placed on myself to fit in. Even as small as my body became as an endurance athlete, never did I want to disappear, shrink, or be absolved from adulthood and responsibility. Responsibility weighed heavy on me.

And, yet again, here I was across from her, silent at the moment, feeling the weighty responsibility of being polite. I felt responsible for playing my part of being thankful that I had made it past the waiting-room door and into the counselling room when others had not. I knew of other males in swimming pools, gyms, bike shops, school hallways, staff rooms, and hostels who were not in counselling rooms. I felt responsible for being grateful that she would help me.

Except the tension was that she was not helping me. She did not listen.

And I did not speak.

As I sit now and write about this incident years later, I wonder-

Was I responsible for telling her I was not a little girl and that I did not hide from responsibility?

Did she have a responsibility to build our counselling relationship such that she could challenge me, and I would feel safe with a rebuttal?

What am I responsible for now after that moment has passed?

The tension was and still is that she never did listen to what I needed her to listen to because from that point on, I never spoke of what I really needed to say.

It's not because I didn't have anything to say. It's because I had too much to say and didn't know where to begin.

Did I tell her that I was not a teenage girl? Did I tell her that I forgave her for only knowing about girls because that's likely mostly whom she saw and read about because most research is about young women? Did she need my forgiveness? Is this the therapeutic relationship I want—one where I'm disappointed and feel the need to forgive?

I've read Surtees's (2009) reflexive research about nurses on the ward with patients who had anorexia. The nurses felt just as much on display as did the patients. Now I feel our relationship is just as much about her as it is about me. I don't want her to feel bad for not knowing. How do I teach my therapist? What voice do I use to do so?

4.4 My Story – Worst Enemy: Not Seen. Then Seen and Reduced

A different workshop. Day 3. A closing reflection.

As each female around the table said they liked what they were fed at the workshop, I knew I did not agree with the majority of the script and I wanted to say so. I wanted to speak up about what I didn't see as leadership at the workshop and the potential dangers of telling people what to think. But I wanted to be polite. I didn't want to bulldoze through the

experiences of others; I wanted to be grateful that I was at the table, that it was for females and I was invited. My responsibility to be grateful kept me quiet.

As well as my trembling fear that if I opened my mouth, the stinking fish would come vomiting out.

The vomit was this:

I wanted to tell the females at the table about the conversation I had had with the one other male at the training weekend. He was the master trainer.

During a nutritional break, he and I started a conversation. I told him my hope was to learn from the weekend and transition my learning from it into a male arena. He told me why this weekend workshop was targeted at females.

His story was that “men are their own worst enemy. We’ve tried to have male groups, and not many show up, and the ones that do often do not speak.”

For a moment I bought into that. It’s a narrative I’ve heard many times in my life: males are a Neanderthal clan who drag their knuckles with bottled emotions, only to grunt feelings like Tim “The Tool Man” Taylor on *Home Improvement* if we need to. But as I turned his message over in my mind at home that night— that it’s my fault there’s no help for me because I’m a caveman—I web-surfed the company’s website, Instagram and Facebook page. I found the image depicted in Figure 13 (below).

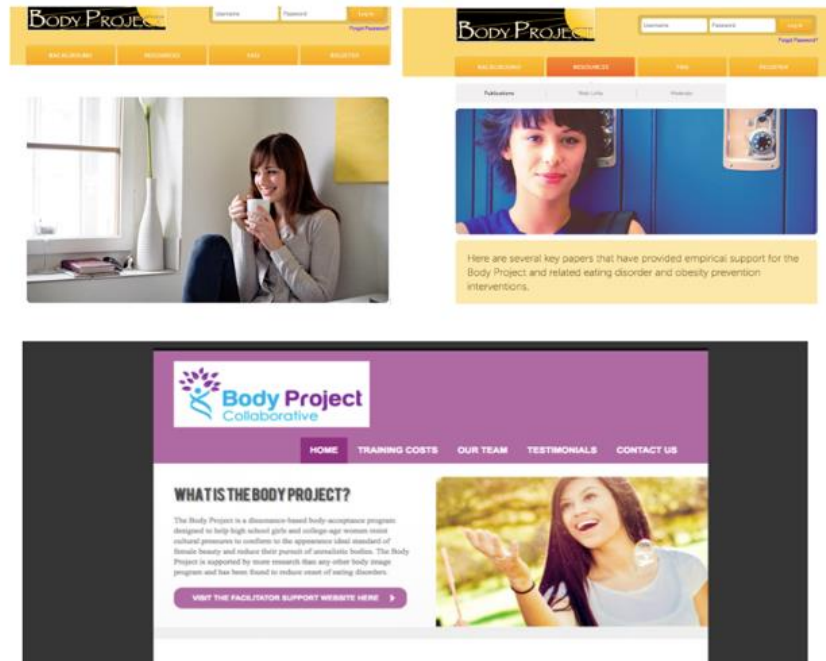


Figure 4.1. Body Project home page. Screenshot of [Home page], by Body Project Collaborative, n.d. (<https://www.bodyprojectcollaborative.com>). Reprinted with permission from Body Project Collaborative.

Men don't speak in the eating disorder arena because there's nowhere for them to speak. I'm not my own worst enemy when it comes to receiving help because I don't speak up. From the Body Project's media platforms, it's clear there are no chairs at the table for a male to sit on, let alone sit and speak.

There may be an argument for me to not single out the Body Project as exclusive because it's intended for females; arguing for male inclusion in this instance might be like me showing up at a hockey game and asking to play basketball. However, the key is to see the Body Project as part of a much broader picture.

I asked my friends to send me screenshots of when they Googled "eating disorders" to discern if it was just my computer's algorithms finding images of females only when I searched for information about eating disorders. Because of copyrights and sourcing issues, I am unable to display many of them in this thesis; however, Figure 4.2 is one screenshot that is similar to the rest.

and Instagram page:

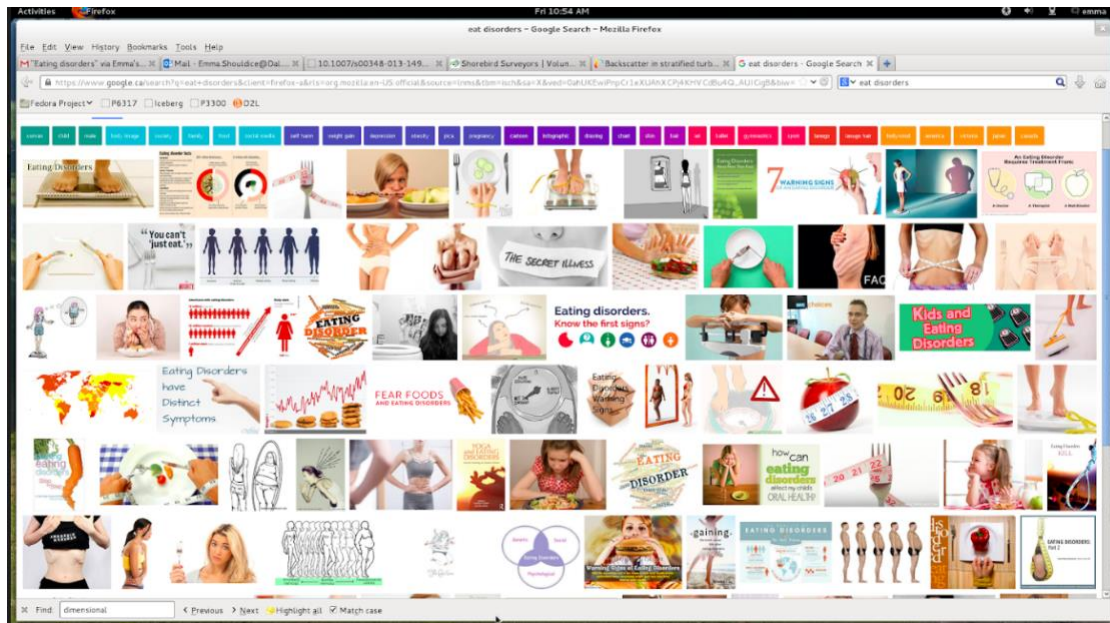


Figure 4.2. Eating disorder images. Screenshot of Google search using search term “eat disorder” on June 30, 2017. www.google.ca/search?q=eat+disorders&client=firefox-a&rls=org.mozilla:en-US:official&source=lnms&tbm=isch&sa=X&ved=OahUKEwiPnpCrleXUAhXCPj4KHVCdBu4Q_AUICigB&biws. Google and the Google logo are registered trademarks of Google LLC. Used with permission.

page:



Figure 4.3. NEDIC home page. Screen shot of [Home page], by National Eating Disorder Information Centre eb page. Received February 10, 2019 (<http://nedic.ca/>). Copyright 2014. Reprinted with permission from the NEDIC Team



Figure 4.4. NEDIC Instagram. Screen shot of National Eating Disorder Information Centre Instagram account. Retrieved June 17, 2017 (https://www.instagram.com/the_nedic/). (n.d) Reprinted with permission from the NEDIC Team

In this gendered landscape, I see that autoethnography is needed and it means bringing my own chair to the table because there are no chairs for me. Autoethnography is sitting at the table and speaking even when it feels like emotional vomit.

As I sat in quiet of my apartment that night, reading through the workshop's social media feeds and thinking back to posters I had seen throughout the years for men's help, I felt uneasy that I had swallowed the facilitator's myth. Ask a coroner doing an autopsy about what they are doing in the lab, and they will tell you they are doing important research, digging for clues. For me as an autoethnographic researcher, I often don't look for clues. I puke them up as emotional vomit. It's knowing that while the dead fish rots, there is important insider

information to be told.

Yet, back at the all-female table after the weekend workshop, I do not speak because to open my mouth at all feels like the rotting fish carcass will vomit out. And it's not simply those instances that made my stomach queasy. It was also how the narrative that the male facilitator at the workshop fed to me about men being their own worst enemy, and the male doctors telling me to "just eat a burger with your beers" as if that's what men do—barbecue and beer all day. Not puking dead fish is not wanting to disrupt the table of positive discussion. It's the bile built in my stomach, when the psychologist gave a dissertation about me and the physician and the facilitator handed me a prescription of manhood. It's me needing to get that discomfort out of my stomach so that they may change what they do. To do this, to get it out, autoethnography is needed.

I'm gonna burst if I don't say something.

If you can't say something nice, don't say anything at all.

I want to speak softly and politely. I fear what will come out is spite: spit at best, vomit at worst. To stop the vomit when my body micro-shook in the chair as the feeling of the room fell in on me, and I felt claustrophobic, and I went hot then cold then hot again in my seat, as I always did, I calmed myself down.

To calm myself I thought the things I always thought about:

Maybe I'm wrong about my experience.

And besides, this isn't the place to share my experience.

Maybe my experience doesn't matter anyway because it's not what seems to be the norm.

"Why can't I think like the rest of them seem to be thinking?"

“The workshop indirectly said, “Think like those of us without body image issues and be resilient like us. Join the rebellion and ignore the evil empire of photoshopped abs.”

Why can't I be cognitively dissonant from all this like the rest of them seem to be?

To calm myself I thought as I always did.

As a way to stay silent, I thought “What do I know?”

4.5 My Story – Captain and Conquer: Seen and Reduced

Yes, finally! Blood work time!

I sat in a male physician's office to get blood work done. My iron had been historically low, and I wanted it checked because I thought I was eating well, and my levels might have returned to normal. Fifteen years into an eating disorder and I'm making good progress. Not out of the woods yet, but I'm sitting proud of myself for coming this far.

The doctor sat across from me, legs spread, clicking his dress shoes on the floor, leaning in, elbows on his knees.

“Blood work. Okay. Why are you looking to get this done?”

I tell him I have anorexia.

“You have anorexia?”

Okay, so my weight is fine. I'm the heaviest I've ever been. Good muscle too. Okay. So maybe at this point I have orthorexia, I still restrict eating and exercise even after I have a sliver of a cookie. But I also binge eat after I have half a bag of them. But I'm not starving and sickly slim. And the weight doesn't matter. And orthorexia isn't in the *DSM-5* anyway so that information is useless to a medical doctor. Besides, it's my brain not my body. My heart and brain are scared that it might all come back. And I still struggle. But blood work. Right. Not therapy right now. Blood work. Simplify my situation so we can move on.

“Yes”, I tell him. “I had it for a long time and had anemia. I’m better now. I want to make sure my iron levels are okay.”

He leaned back in his chair, tapped his pen on his desk, then leaned in again.

I came for a blood test.

He began his speech.

He leaned in and told me about “Manning Up.” Of being the master of my own ship and taking control of my own life. He told me to be the captain. That if I wasn’t in charge of my life, who was? He ended his speech by telling me to head downtown, just eat a few cheeseburgers and drink a few beers. He then asked me how my sex life was. I assume this was because of a correlation of low iron with low libido.

But I don’t know if that was his line of reasoning.

As with the psychologist, I didn’t answer the direct question. Instead, I mumbled out a “Good” to be polite.

After his monologue, I felt small and stuck.

Stuck between a rock and a hard place.

The rock was that I felt like an empty shell who didn’t get it right. I felt crushed. Someone who missed the memo on how to live a man’s life. I felt small enough that I didn’t know where to begin to explain to him that his crass concept of masculinity was not helping. Men aren’t out conquering the world as masters and captains. Or, at least, they ought not to be. I wasn’t and had no interest in doing so. But there he was in his office, in his shiny shoes and his doctor coat, telling me how to be, how to not be who I was, because apparently who I was was not a captain of the ship.

The hard place was that I wanted to lean into his space and tell him all of this. That I'm doing quite well actually. That I just finished reading the APA's, *Guidelines for Psychological Practice with Boys and Men* (2018). They talked about traditional masculinity being a problem, that the assumption that I need to be competitive and dominant is unhealthy.

The hard place was that I told him none of this. I felt small because I also thought, if I had got this right in the first place, if I had been the captain of my own ship, I'd never have had anorexia in the first place. That long ago I should have just eaten the damn burger and fries. But not too many fries. Right? Be the captain. But a well-chiselled captain. Make sure I still have good muscle tone with all those burgers and beer.

I was there to ask for a blood test, not feel like I needed to unpack the ideologies of masculinity and its problems while sitting across from a doctor who had just told me that following the man rules would save me.

So, to get myself out of the jam, I said nothing.

I thanked him for the blood-test referral. Told him I sure would have a burger and went on my way.

4.6 Researching Impact

As I sit and type these stories from old hand-scrawled journals, I wonder if I too am being reductionist about these individuals' experiences with me. Perhaps they were aiming for more than what I felt. Their intention was not to have the impact it did. What I know of my experience is that in trying not to say, "What the eff—are you even listening to me?!" I instead said nothing and asked myself, "How do I talk about personal issues without getting too personal at the person sitting across from me?"

But, grateful to be in a room, in a conversation at all, I didn't want to bite the hand that fed me, so I wondered how I could talk about the impact. How do I tell the other half of the story?

To answer my questions, I need to respond to the noise rather than listen to the noise again.

Chapter Five

Outcomes

5.1 My Story – What Did I Learn?

[I sit in a chair next to Leah and Sarah. Two years after we started this project.]

I'm after putting these stories in my research, moving some stories around; seeing how they fit together in themes or sequences. I know what my response to the noise of stereotypes is: this thesis.

I ask myself what I have learned from telling these stories.

I want to move my stories beyond myself and into the “ethno” of ethnographic research.

Next is the process of reframing my experiences from opportunities missed to lessons learned. I ask myself the “so what?” of it all. I begin to look at empowering themes that have emerged.

While I'm sitting there turning this over in my head, Leah asks, “Ellis suggests that autoethnographic researchers should know and understand more at the end than we did at the beginning. So, what are we looking at here in this section?”

Now the question is out loud. What did I learn?

The answer is obvious to me. In large part because I was so damn apologetic for my client voice.

I've learned about the agency in speaking and understanding my own experience as a site of knowledge. That I am the expert of my experience as someone with an eating disorder. Yes, there is practitioner knowledge and expertise, but so too is there client expertise. More so, I think about the practitioner role in helping clients access their agency. When I first began

this research two years ago, I thought I was writing a “how to” for other men to write their own research. I thought I was providing a blueprint for them to take their voices into their own hands. Today I know this is not the case. If it took me this thesis to tell my story, if it took me two supervisors with PhDs, two years and a lot of support, what does this say about the possibility of other people with eating disorders, who do not have access to writing a graduate thesis, to be seen and heard and have their voices valued? If it took me two years with support from my supervisors to get my researcher ears to listen to my client voice and to get my client voice to move from quiet, to apologetic, to having knowledge and agency, what does this say about others who may not have the same supports? I’m not saying this to make assumptions about the lives of other people. But what do they do?

Leah asks me to put on my counsellor hat and asks my questions back to me: “What do you think they are supposed to do?”

I think about what I said. What do marginalized people do to have a voice that’s heard? They do nothing because they are not supposed to have to. We do something. With my counselling hat on, it’s my job. We counselling therapists, we let them know we’re out there to help. Posters, signs, webpages. We researchers, we find their stories and make them heard. And we who inhabit the slash. We autoethnographic researchers, we research to bridge the gap between out- and inside knowledge. It is the responsibility of professionals to make space and to be there to help. Responsibility. I thought that word might come up again.

5.2 Illumination

Autoethnography has the ability to use a researcher's personal experience—that is, their stories—to illuminate the culture under study (Ellis & Bochner, 2000). What has been illuminated for me is that a marginalized male client voice is a difficult one to speak with.

What has been illuminated for me are the small ways in which researchers and counselling therapists can make a space for that voice to be heard, listened to, and affirmed.

Through this research I have learned that my client voice has agency. My learning happened in the process of telling, editing, and retelling these stories. Narrative therapists Winsdale and Monk (2007) proposed “the simple but profound notion that stories, rather than hard-nosed realities, shape our lives” (p. viii). I have learned about the power of using the client voice to tell stories and the valuable knowledge in lived experience.

My intent was to separate my learning into three categories: what I learned at a counsellor, what I learned as a researcher, and what I learned as a client. Autoethnography, (that is, inhabiting the slash) means it is difficult to make these separations. These categories of learning are entwined; therefore, separating them would pit each identity against the others rather than have them work in harmony to tell a rich story. For me, this is an empowering lesson: The whole is greater than the sum of its parts. The affirmation of the intersections of one’s identity can provide more agency than to separate each identity.

Client perspective-centred research and treatment is a way for clients to access their agency without being reduced to a stereotype of gender or of a stereotype of a client who is ignorant of their experience. When a client is seen and listened to as a whole person rather than a gender stereotype, agency is placed in their hands.

Chapter Six

Outcomes Become Implications

In this chapter, relevant lessons learned from the past are used to inform what those responsible for research and treatment might consider at present and in the future. The following two stories and their analysis illustrate that the whole is greater than the sum of its parts. In other words, the stories demonstrate that an individual's experience with an eating disorder is greater than the gendered and reduced sliver of identity afforded through marginalization. This realization positions research, media, and treatment as responsible agencies for fostering spaces, be they physical, relational, or psychological, for clients to access experience of agency. It also highlights how clients can access their own agency through the help of research, media, and treatment. It is also worth considering an *and-also* paradigm for eating disorder research, media presence, and treatment. This is to say, additions to what research, media and treatment is already in place, ought to be also considered.

In the first story, "Do We Need Hockey Posters?" I write from an insider perspective of marginalization through gender stereotypes. In the analytic follow up, I illuminate the *and-also* paradigm. In response to gender stereotypes it seems relevant to consider how gender diversity is understood in eating disorders. It means keeping books and literature about female experiences, (and also) adding male experiences, (and also) adding genders outside of this binary to what is seen and affirmed in the eating disorder world.

The second story, "Selling Salvation: Can an Agnostic Recover?" explores marginalization through dichotomizing expert practitioner knowledge and client experience. In the follow-up analysis, I use the *and-also* paradigm to examine keeping medicalized and mechanized models of eating disorder treatment *and also* adding counselling therapy that

values a client's expertise in their experience and the role of their perspective in treatment (Gillard et al., 2016).

6.1 My Story – Do We Need Hockey Posters?

Amy, closed the door, sat down, and we began to chat in her office in the therapy clinic.

She first asked about how the treatment was going. I liked her questions and our conversation because she didn't ask how The Disorder was going.

I appreciated that.

What she always meant was, "How are we doing as a team at the clinic?"

I knew where she was coming from because she told me.

She has a close friend who is an emergency room doctor and sees males who look fit from the outside but appear to be 80 years old on the inside. They have low testosterone paired with impaired nutrient metabolism and are coming into the hospital on the borderline of cardiac arrest.

For years I could never give blood because I was anemic, yet no doctor ever expressed concern.

"You're young and fit; it will pass," I was told.

Amy saw the problems I was experiencing. She knew that males tend to revolve through the eating disorder landscape without proper assistance. She asked what to do with all this— what to do for all the males who pass through looking for welcome signs.

And she meant this. She was looking for answers as much as I was. Then she said, "I don't know. Do we need a few hockey posters up around here?"

What a colour wheel of emotions I had when she said that.

I don't remember my response.

I do remember feeling at first elated.

I felt joy that someone, to me, in my presence, to my face, acknowledged an ongoing issue and asked me about it. Someone included me in the solution. She saw me as an agent in my own transformation. She saw me as an equal. Like I knew something. Because I did know something. I wanted to hug her for asking me that question.

I felt soooooooo good.

I also remember the second wave of emotions. One of a dissolved identity when matched against the stereotype of a male as an athlete. Matched against the assumption that men equal sport, and that I would self-identify as such. And it's not hockey that's the problem. In Canada it's hockey. In New Zealand it's rugby. In the United States it's *Sunday Night Football*. In Belgium it was cycling. Hockey posters would only recycle that stereotype—alpha male, sport, muscles, winning. Yes, I went to the gym. I biked, skied, and surfed. Still, I was more than this reduction.

My brain flooded with images of a sporting man. Boxers with blood on their fists. Hockey players hitting other players into the boards. Cycling's Tour De France winners on the podium being kissed by two women in dresses. "Podium Girls", they're called. Their sole purpose is to be eye candy and kiss the triumphant men in front of the flashing cameras.

I thought, "Do we need more of this around?" Do we need more images of a man "being a man"? Yes, the flood of images I just had are a snapshot of what's out there. All media of men are not all bad.

Then my brain flooded with a ramble of reasons why a hockey poster is a bad idea. Hockey posters, or any other poster with a male, will do little to decouple and unwind the

gender-binary-perpetuated masculine media.” Masculine media? What is that? *GQ* and *Men’s Health* magazines? The airbrushed models who presumably cause men to get eating disorders in the first place? I certainly didn’t get anorexia because of shirtless Brad Pitt on the cover of a magazine. Also, there are deeper issues of representation within minorities to unpack. Minority, as in I don’t play hockey; I don’t play rugby. Jock posters would do nothing for me. Or would they? Are they something better than nothing? But what if the something just makes things worse? Amy just asked a simple question, Shannon. Answer it.

I stopped my brain from spinning.

I answered her question.

Her question was such a warm embrace.

I answered, “Yes.”

6.2 Reflection

I don’t remember our conversation after that. Ten years after this incident, as I write this story and retell it to Sarah and Leah, I tell them it would have meant the world to me to see a stupid hockey poster.



Figure 6.1. Hockey poster. Screenshot of Break the silence [Tweet], by Vancouver Canucks [Canucks], February 2, 2019 (<https://twitter.com/canucks/status/833073630015741952>).

Had I seen something like Figure 6.1 above in the therapy clinic after my conversation with Amy, I would have wept. I almost did when telling this story to Sarah and Leah to highlight the importance of being seen and acknowledged.

6.3 Treatment Implications

It seems relevant to consider how gender diversity is understood in eating disorders. Arguably, placing posters of sportsmen in clinics is a band-aid solution that simply recycles the male stereotype. However, given the current eating disorder climate, a male picture in the room is a start. To be sure, it does not remedy marginalization. In clinics, diverse gender representation might look like placing books, posters, and any program materials that show gender diversity where individuals can see them.

Understanding and acknowledging gender diversity and gender as a spectrum may also help mitigate potential gendered treatment. Diemer et al., (2018) explored the experiences of transgender adults and advocated for a variation in mental health needs across spectrums of gender identity. They stated increasing “clinical providers’ competence in gender identity represents an important public health approach to reducing health inequities beyond the gender binary” (p. 22). While Diemer et al.’s (2018) research was specific to the experience of people who are transgender, their call for an understanding of treatment paradigms beyond the gender binary may also serve well for anyone not wanting not be reduced to a gender stereotype.

When asserting that eating disorders are, as her research title says, “Not just ‘a white girl’s thing’” Bordo (2009) acknowledged that while there is “potential for inclusiveness” in eating disorder discourse, a master plan to alter this culture is not an easy one to create and

implement (p. 57). Still, by deepening understanding of gender diversity and how it is seen and affirmed, strides can be made to decouple the current gendered eating disorder landscape.

6.4 My Story – Selling Salvation: Can an Agnostic Recover?

“Yes, this one will work!”

Dr. Kristin gave me a book and I was happy about it. Kristin is a psychologist at a therapy clinic. Part of her practice is to use *bibliotherapy*.

I had read about bibliotherapy and was interested in trying it myself as a client.

In a nutshell, bibliotherapy is using books, or any text really, to help a client in therapy. I’ve seen rows upon rows of self-help books in Chapters and Coles. This was different. The book Dr. Kristen gave me was from a well-established psychiatrist, and from the book’s claims, “the world’s foremost authorities on problem eating” with hundreds of thousands of books sold in multiple languages. Dr. Kristin was going to guide me through the book. As we chatted about what her guidance would look like, I thumbed through the pages with excitement. There were a few excerpts from stories of real people going through the same issues I was.

I went home and began to read. On page one, the book boasted that it would provide me with an authoritative account of eating problems and how to fix them. The next paragraph in the book claimed to be well-researched enough to solve “any eating problem.” The paragraph after that exclaimed that professionals prescribe the book like it is medication.

Ooh, I thought, I don’t need medication. I’m not sick. I don’t need an authoritative account of an eating disorder. An eating disorder is not carpal tunnel syndrome; I don’t need my transverse carpal ligament released. The author of this book hasn’t even met me, and already on page one he’s curing my ‘any-eating-problem.’

I sigh.

Don't resist.

Continue reading. He's the authority. He says so.

And I did read. And I tried to read.

The next week back at Dr. Kristin's office. I asked her more about how we might work with this book because of some of the reservations I had with it. I explained to her, I was not looking for information about eating disorders, I already had one. I wasn't interested in the chapter about the prevalence in what genders, ages, groups, or other demographics anorexia occurs. I wasn't interested in the chapter about the poor health outcomes of an eating disorder.

"Not that those things aren't important," I say, "but because I know these things already. I'm living the poor health outcomes. I know them."

"I've had anorexia for 15 years. Can we do something besides read a book?"

"Shannon," She leans in, "this is the eating disorder talking. Resisting treatment."

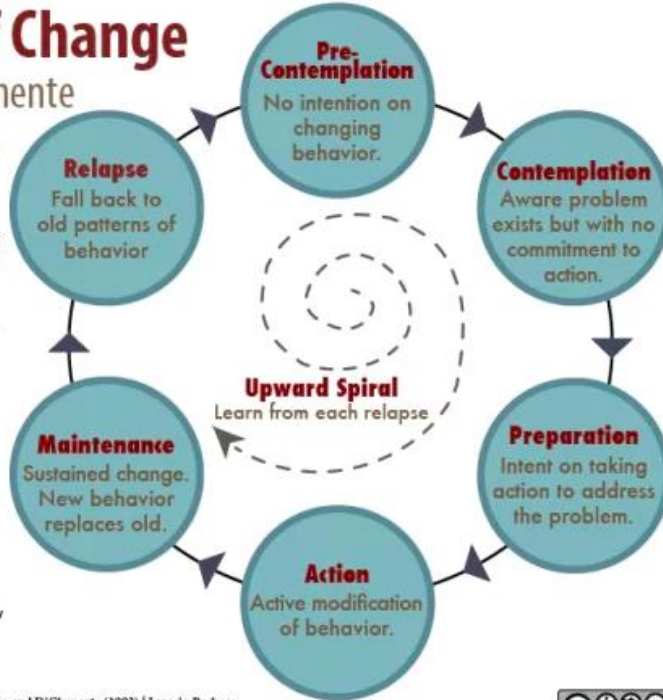
And then.

Then Dr. Kristin hauled out the sinner graph:

The Cycle of Change

Prochaska & DiClemente

- **Precontemplation:** A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists
- **Contemplation:** The person becomes aware that there is a problem, but has made no commitment to change
- **Preparation:** The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client is convinced that the change is good) and increased self-efficacy (i.e. the client believes s/he can make change)
- **Action:** The person is in active modification of behavior
- **Maintenance:** Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional
- **Relapse:** The person falls back into old patterns of behavior
- **Upward Spiral:** Each time a person goes through the cycle, they learn from each relapse and (hopefully) grow stronger so that relapse is shorter or less devastating.



The Cycle of Change
Adapted from a work by Prochaska and DiClemente (1983) | Ignacio Pacheco
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Figure 6.2. The cycle of change . Screenshot from “The stages of change (Prochaska & DiClemente, 1983)” [Blog post], by I. Pacheco, January 9, 2012 (<http://socialworktech.com/2012/01/09/stages-of-change-prochaska-diclemente/>) Licenced under Attribution-NonCommercial-NoDerivs 3.0 Unported.

Oh, boy. I’m in trouble now.

It was Prochaska and DiClemente’s 1983 model for stages of change (Figure 6.2).

According to the experts, when The Eating Disorder talks, it means I’m not ready for change or treatment. I’m in the contemplation stage; aware of my problem but having no commitment to action.

I feel like a kid. Not kid-in-a-candy-shop kid (though the obesity-epidemic police would argue that’s bad too), but the scolded-kid-in-the-corner feeling of being a kid.

I feel small and deflated. Trying to move myself from feeling like a kid, I begin to feel angst. Great, a teenage feeling. Like I’m about to whine to my Mom that no one understands.

I’m whining. I’m whining again—Am I?

Either way, neither of these two identities, child nor teen, sit uncomfortably in my body.

“It’s the eating disorder talking.”

I’ve heard this statement made before to others in group therapy.

At 3:00 a.m., when the fridge door is open and my hand is wrist deep in yet another jar of peanut butter, and my brain is spinning and spinning and spinning and the world is closing in, and I think, “Fuck it, I’ll destroy my sad-sack-of-shit self and go for the cake to...” Then, yes then, it’s the eating disorder talking. But when you’re sitting across from me and asking me to fill out yet another CBT chart in a book that you can’t even backup as to why I am doing it, other than you reciting babble from yet another book, then no. No, it’s not the eating disorder talking. It’s my own brain, my own adult, fully-functioning, autonomous brain.

But I say nothing.

I hold back my emotions to save Dr. Kristin from the splatter of anger and disappointment.

It’s not easy to ask for help and get into a counselling room. To ignore the gendered media, the doctors and their barbecues-and-beer advice, to sit through group therapy with teens and their mothers, to fit the *DSM-5* diagnosis to get in when my body size looks good, so to finally be in a counselling room one on one, face to face—being here is important to me. I don’t want to get left out of this too.

If I clash with the authorities, the experts in the field, if I risk excommunication from the stages of change from Prochaska and Diclemente, then where do I go?

“Ok,” I say to her. Let’s take a look at the food list on page 19, and we can see what I’ll eat for supper tonight.”

I can see her excitement. She turns to her book shelf and hands me a pamphlet of *Canada’s Food Guide*.

Great, another prescription!

“You know,” I say, “I think that changed last week. Though I’m still curious why they are against saturated fat. It occurs naturally in free-range, grass-fed animals. Research from Uffe Ravnskov...”

I trail off as I sense her discomfort.

My brain is spinning with thoughts.

Obedience is sold as salvation; you eat cereal and bread; the body of Christ. You follow the bibles of cognitive-behavioural therapy and workbooks about perfectionism. Never mind that in South Korea I ate samgyetang for breakfast and am hardly perfect in anything I do, and that doesn’t matter to me in the least. I went to theatre school: perfection is the death of creativity. I’d never walk on a stage if I thought of perfection. Obedience to perfection is the death of life. Ok, now I’m sounding like a teen. Wah wah wah. Shannon, be quiet. Keep your brain quiet.

Except I can’t. No words leaving my mouth, I continue to think.

Eating disorder therapy was being packaged and sold to me like a religion. It was based on following the rules to recovery, a salvation that promised to set me free from the eating disorder devil’s voice. If I didn’t follow the food guides or meal supports or complete the pages and pages of food-fears worksheets, then I would not recover. Recover. What does that word even mean? Return to my innocent state before all this mess began? No, I’d rather

grow and adapt then cover up or return. But here I am; I feel faced to return to my sinner-self, still worshipping false idols of glossy magazine covers of other deities rather than bowing to serve the deities of evidence-based practice.

I don't want to disrupt the gods. I need to believe in something for a while.

I need my brain to stop rattling and my mouth to open.

"Never mind" I say, "let's have a look at what cereal I'll eat tomorrow morning."

Dr. Kristin leans back in her chair and looks uncomfortable.

Crap, maybe my "never mind" spat out a bit harsh. Oops. Sorry. I'm sorry. But also, I'm tired of all this. I don't want therapy to be a game. It feels like I'm here to make you feel good about your job. Perhaps I should go. Come back when I'm a bit more fresh and ready.

Then Dr. Kristin says, "Shannon, how about we dial it back a notch? Seems like you're not interested in the book I have to offer. And, please correct me if I'm wrong, you don't really seem interested in talking about food. Let's take a minute to check in, see what we can do. How are you feeling right now?"

Oooooffffff.

I don't remember exactly what I said.

I do remember the floodgates opening.

Holy crap, she saw me.

She was listening.

Ok, don't blow this. Say something. Now is your chance. Say something. Tell her why you're here.

In kindness and with a huge sigh of relief because she saw me and listened, I began to speak.

“Okay,” I said.

6.5 Treatment Implications

This story highlights the importance of the client having a choice of what they want to do based on context. It is not an argument for which diet or mode of therapy is best; rather, here it is relevant to consider valuing a client’s expertise in their experience and the role of their perspective in treatment. Rance et al. (2015) called for “developing more holistic approaches” (p. 52) to treatment plans. They also contended that resistance (“that’s the eating disorder talking”) from a client may be not rebellion against gaining weight; rather, it may be a sign that current treatment is not working. Counselling therapists’ and treatment teams’ ability to listen to the client’s inquiry and struggle and explore that conflict with them may lead to clients accessing their own agency at a treatment impasse.

More important, even when not at an impasse, certain counselling psychology scholars have invited consideration of the act of therapy as social construction between client and helper (Gillard et al., 2015; Tilsen & Mcnamee, 2014). Their research suggested a positive correlation between collaboration, alliance in the client-practitioner relationship, and healthy outcomes, including facilitated change and agency (Gillard et al., 2015; Tilsen & Mcnamee, 2014).

Gillard et al. (2016) suggested respecting experiential knowledge as a valid source of evidence when collaborating. Tilsen and Mcnamee (2014) expanded on valuing the client experience and asserted that, “clinical creativity, our professional judgment, and our clients’ preferences, uniqueness, and voices” increase the client’s likelihood of progress (p. 12). Gillard et al. (2016) also found that coupling client voice and experiential knowledge with practitioner expertise was a predictor of positive outcomes.

6.6 My Story – Research Implications

“I ruined my flow. I’ve got no story.” I say to Sarah.

The three of us, Sarah and Leah and I, are having another meeting.

I want to discuss the research implications attached to the stories, “Selling Salvation” and “Do We Need Hockey Posters?” So far, I’ve been telling a story to situate my analysis. This time, I have no research story except this, my thesis.

I tell them, “This section is supposed to acknowledge that autoethnography is a good fit for those times when we can’t separate the slashes in our identities, when we need to research something as a whole rather than a fractioned and reduced piece. But I have no story to tell about this.”

Leah asked me what I meant. “No story?”

“Nope. No story.”

I remember being at Simon Fraser University in British Columbia and seeing posters asking for research participants for various eating disorder studies. The studies asked for specific qualifiers in participants, such as a medical diagnosis of an eating disorder via the *DSM-5*. I saw the same in New Zealand too. Eligibility criteria also often specify that participants not have been a part of any other treatment program. For example, the two I saw in BC wanted to study if a three-week anxiety management course may work on someone with anorexia. I was already in therapy so was ineligible. New Zealand was similar. And I get that. I understand that’s how some research has to be done. I remember reading about it in our research-methods class. Participants need similar characteristics to confirm the results will be because of what is under study and no other factors. Specific eligibility criteria help achieve accurate and valid results. Totally get that. But, I’m not a specific person. I’m a mixed bag of

being a long time undiagnosed. Then seeing social workers, psychologists and counsellors, all who tried different modes of therapy. There's nothing precise or measured about my life as someone with an eating disorder.

We all pause for a moment. Then Leah reminds me of the and-also paradigm I describe at the beginning of Chapter 6. She reminds me I'm not suggesting this type of controlled-research change, I'm asking to include narrative research and autoethnographic research in the mix. And it's already there. We just need more of it.

That's right. I was a part of a narrative study on athletes with eating disorders. That fragment of my life was told by another study. Elzen (2018) interviewed five men in St. John's who identified as athletes or coaches. Her research will benefit coaches, athletes, teachers, parents, and so on. It's great and we need more of it. And also, we need research not just focusing on athletes. This is where autoethnography comes in. Individuals can become researchers who explore multiple identities within themselves as intersections rather than dissections. For example, "an athlete" also has room to examine being "a mother" and "an engineer." We're not getting caught up in specific qualifiers of who and what can be a subject in eating disorder research.

6.7 Diverse Perspectives

Autoethnographic research can enable diverse perspectives and voices to be heard and understood. And it means that included in knowledge creation is the person with an eating disorder. By offering a client's own defined experience of gender, or of being an athlete, or of being a teacher or nurse, or of being a parent, or of being anyone, anyone with an eating problem, disorder or another label they need to use told through any identities that inform their experience. Through autoethnography other people can better comprehend the

experience of an individual with an eating disorder rather than a stereotype with an eating disorder. This is a benefit for eating disorder treatment in general. It is also a benefit for counselling psychology specifically, because valuing a client's lived experience and understanding their expertise as valuable data is an important aspect of the therapeutic relationship (Corey, 2017; Jones-Smith, 2014; Tilsen & Mcnamee, 2014). Research methods that are client perspective-centred add valuable insider, reflective, and evocative findings relevant to counselling therapists who use person-centred approaches in treatment. Therefore, research that acknowledges and values an individual's experience bolsters a more intimate and nuanced understanding of an eating disorder experience.

So, I have no section for an analysis per se. At least not the same kind of analysis that preceded the other stories in this thesis. By investigating why there was no research story for me to tell in this chapter, I have come to understand a need for more narrative and autoethnographic research to tell the untold stories and illuminate ones in the shades of grey that don't quite fit the exact palate of controlled studies. In this way, my analysis is a call for diversity in the way researchers study eating disorders.

Chapter Seven

Future Directions

My Story – Time to Speak.

“Okay.” I said.

I wanted to answer Dr. Kristin’s question about how I was feeling after she handed me a food guide.

My body and mind flashed back to Donna, the receptionist at the clinic in New Zealand, when she asked if I needed anything. I wanted to answer her too. I wanted to chat more with Amy in British Columbia, who asked me about hockey posters. I wanted to talk with Joan, the social worker I did therapy with in South Korea.

It was time to speak.

So I did.

I answered Dr. Kristin.

I told her about feeling marginalized and not listened to. I told it was hard to be in her office in the first place because of all the gendered posters and pamphlets. I told her I’m not resisting therapy; I’m resisting feeling reduced. I told her I’m exhausted from the fight. Not against the eating disorder but for trying to be heard, for trying to be polite and say thank you even though what I was being given was not working for me. That I felt tired and alone when I had no space to speak. Or that when I did speak, I was told it was my eating disorder talking and not me, not Shannon. That I thought, “Where am I in all of this? Am I even here? Because it is me speaking. It is me, Shannon. Speaking.” I told her I’m tired of my feelings of being reduced. That when I’m handed a prescription of what to do without my input, I feel a wall put up; communication over. I told her I felt alone. Done. Checked out. Alone.

I slouched in my chair in sobs.

I finally vomited.

Fuck. Now what? This is it. My last exit.

And Dr. Kristin slouched in her chair too.

We both sighed.

There was silence.

Because she was listening.

She listened.

She listened, and then she said, “Shannon. Yeah, I hear you. Thank you. This is important here. Tell me more.”

Pooooooooooooooooooooo.

And the world opened up.

Small actions make massive, massive differences.

My speaking,

her listening,

led to a discussion.

We talked.

I spoke. She spoke. We listened.

We had a conversation.

We had a conversation, and it felt so good.

So, so good.

It was no longer a one-way monologue.

I was there. Finally there. In the room with her.

We did something together.

We talked.

We talked about me as Shannon, a mixed bag of heaps of identities. We talked about me being more than a student to fill out pages in a workbook. We talked about her and me as a team.

We talked about being vulnerable within parameters. She disclosed her reservations about not following evidence-based interventions, or yes, following them but she and I together being able to pick and choose. From there, we talked about the and-also of it all; not throwing away her (as she called it) “bag of tricks” but using it in consultation with me. We talked about not much needing to change. But there we were—changing. Us, talking about the excitement of creating new things, chasing curiosity and exploring possibilities.

My unravelling took up the rest of the session.

Dr. Kristin politely told me time was up, and we’d see each other again next week.

As I put my hand on the door to leave, Dr. Kristin said, “You know, don’t silence your voice when you think you have something valuable to say. People might like to hear it.”

Turns out my unravelling was my becoming...

7.1 Concluding Thoughts

...a researcher.

In this thesis I have layered my narrative of having an eating disorder with my process of becoming an expert in my experience as a researcher and as a client. I have then situated both experiences with those of other men who have eating disorders. This autoethnographic study revealed perspectives relevant to counselling practitioners. By intimately investigating what it means to not be seen and when seen to be reduced, I have come to understand the role

of researchers and counselling practitioners in helping clients create expertise and agency within themselves. I have also come to understand that a small nuance of a behaviour, a simple act from a counselling practitioner, can have a profound effect on a client and render advocacy and treatment more beneficial.

Individuals conducting research or providing treatment might consider how gender diversity is understood in eating disorders. Further, they might also reflect on counselling therapy that values a client's expertise in their experience and privileges the role of their perspective in treatment. The purpose of this research was to understand the experience of a male with an eating disorder as he engages in research and also counselling therapy. By doing so, I was able to raise awareness of the responsibility of researchers and counselling practitioners to provide an opening for men to express their nuanced personal stories.

References

- [#eatingdisorderrecovery]. (n.d.). [Search using #eatingdisorderrecovery]. Retrieved December 10, 2018, from <https://www.instagram.com/explore/tags/eatingdisorderrecovery/?hl=en>
- [#edrecovery]. (n.d.). [Search using #edrecovery]. Retrieved December 10, 2018, from <https://www.instagram.com/explore/tags/edrrecovery/?hl=en>
- Adams, T. E., & Manning, J. (2015). Connecting the personal and the popular: Autoethnography and popular culture. *The Popular Culture Studies Journal*, 3(1&2), 187–222. Retrieved from <https://tonyeadamshotcom.files.wordpress.com/2015/09/manningadams-auteothnographypopularculture.pdf>
- Adams, T. E., Holman Jones, S., & Ellis, C. (2015). *Autoethnography*. Oxford, UK: Oxford University Press.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed). Arlington, VA: Author.
- American Psychological Association, Boys and Men Guidelines Group. (2018). *APA guidelines for psychological practice with boys and men*. Retrieved from <https://www.apa.org/about/policy/boys-men-practice-guidelines.pdf>
- Anderson, L. (2006). Analytic autoethnography. *Journal of Contemporary Ethnography*, 35(4), 373–395. doi:10.1177/0891241605280449
- Andrew, S., & Halcomb, E. (2008). *Mixed methods research for nursing and the health sciences*. Oxford, UK: Wiley-Blackwell.

- Applequist, J. (2014). "The part too often left out involves the perspectives of patients": Helping health-care providers understand the material reality of the everyday for individuals with eating disorders. *Journal of Medicine and the Person*, 12(3), 118–124. doi:10.1007/s12682-014-0186-1
- Ashuk, R. (2004). *Narratives of males with eating disorders* (Unpublished master's thesis). University of Saskatchewan, Saskatoon, SK. Retrieved from <https://core.ac.uk/download/pdf/55300700.pdf>.
- Beausoleil, N., & Petherick, L. (2015). Taking Up the Vitality Message: Health Knowledge, Feeling Good, and Pleasure in Newfoundland Children's Drawings and Talk. *Cultural Studies ↔ Critical Methodologies*, 15(5), 407–416.
<https://doi.org/10.1177/1532708615611722>
- Becker, A. E., Franko, D. L., Speck, A., & Herzog, D. B. (2003). Ethnicity and differential access to care for eating disorder symptoms. *International Journal of Eating Disorders*, 33(2), 205–212. doi:10.1002/eat.10129
- Bochner, A. P., & Ellis, C. (2016). Evocative autoethnography: Writing lives and telling stories. Retrieved from https://www.researchgate.net/publication/305221646_Evocative_Autoethnography_Writing_Lives_and_Telling_Stories
- Body Project Collaborative. (n.d.). [Home page]. Retrieved February 3, 2019, from <https://www.bodyprojectcollaborative.com>
- Bohart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. Duncan, S. Miller, B. Wampold, & M. Hubble, (Eds.), *The heart and soul of change: Delivering what works in therapy*. (2nd ed., pp. 83–111).
<http://dx.doi.org/10.1037/12075-003>

Boodman, S. (2007, March 13). Eating disorders: Not just for women. *The Washington Post*.

Retrieved from <http://www.washingtonpost.com/wp-dyn/content/article/2007/03/09/AR2007030901870.html?noredirect=on>

Bordo, S. (2009). Not just “a white girl's thing”: The changing face of food and body image problems. In H. Malson & M. Burns, Eds., *Critical feminist approaches to eating disorders* (pp. 46–59). New York, NY: Routledge.

Bowman, G. (2008). *Thin*. Penguin Group USA.

Bowmen, M. (2018). *The lived experience of transgender individuals with eating disorders*.

Retrieved from https://via.library.depaul.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1256&context=csh_etd.

Brown, H., & Grange, D. L. (2011). *Brave girl eating: A family's struggle with anorexia*. New York, NY: Harper.

Burch, H. (1973). *Eating disorders: Obesity, anorexia nervosa, and the person within*. New York, NY: Basic Books.

Bundros, J., Clifford, D., Silliman, K., & Neyman Morris, M. (2016). Prevalence of orthorexia nervosa among college students based on Bratman's test and associated tendencies. *Appetite*, 101, 86–94. doi:10.1016/j.appet.2016.02.144

Bunnell, D. W. (2015). Gender socialization, countertransference and the treatment of men with eating disorders. *Clinical Social Work Journal*, 44(1), 99–104. doi:10.1007/s10615-015-0564-z

Burgunder, B. [@brittany burgunder]. (2018, November 26). Screenshot of I've worked relentlessly to overcome obstacles and build my strength... [Instagram photograph].

- Retrieved December 13, 2018, from <https://www.instagram.com/p/BqvONecn7D5/>.
- Cachelin, F. M., Rebeck, R., Veisel, C., & Striegel-Moore, R. H. (2001). Barriers to treatment for eating disorders among ethnically diverse women. *International Journal of Eating Disorders*, 30(3), 269–278. doi:10.1002/eat.1084
- Canada. Parliament. House of Commons. Standing Committee on the Status of Women. (2014). *Eating disorders among girls and women in Canada: Report of the Standing Committee on the Status of Women* (No. 4): 41st Parl, 2nd sess. Retrieved from <https://www.ourcommons.ca/DocumentViewer/en/41-2/FEWO/report-4>
- Charon, R. (2008). *Narrative medicine: Honoring the stories of illness*. New York, NY: Oxford University Press.
- Chistou, T. (2009). Dead, shed skin: An autoethnography. *JCT: Journal of Curriculum Theorizing*, 25(2), 38–47. Retrieved from <http://journal.jctonline.org/index.php/jct/article/view/CHRDS>
- Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th ed.). London, UK: Routledge.
- Corey, G. (2017). *Theory and practice of counseling and psychotherapy* (10th ed.). Boston, MA: Cengage Learning.
- Crawford, R. (1980). Healthism and the medicalization of everyday life. *International Journal of Health Services*, 10(3), 365–388. doi:10.2190/3h2h-3xjn-3kay-g9ny
- Creswell, J. W. (2014). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (5th ed.). Harlow, UK: Pearson Education.
- Defenbaugh, N. L. (2008). “Under erasure.” *Qualitative Inquiry*, 14(8), 1402–1424. doi:10.1177/1077800408322579

- Dell'Oso, L., Abelli, M., Carpita, B., Pini, S., Castellini, G., Carmassi, C., & Ricca, V. (2016). Historical evolution of the concept of anorexia nervosa and relationships with orthorexia nervosa, autism, and obsessive-compulsive spectrum. *Neuropsychiatric Disease and Treatment*, 12, 1651–1660. doi:10.2147/NDT.S108912
- Diemer, E. W., White Hughto, J. M., Gordon, A. R., Guss, C., Austin, S. B., & Reisner, S. L. (2018). Beyond the binary: Differences in eating disorder prevalence by gender identity in a transgender sample. *Transgender Health*, 3(1), 17–23. doi:10.1089/trgh.2017.0043
- Dunn, T. M., & Bratman, S. (2016, April). On orthorexia nervosa: A review of the literature and proposed diagnostic criteria. *Eating Behaviors*, 21, 11–17. doi:10.1016/j.eatbeh.2015.12.006
- Easter, M. M. (2012). “Not all my fault”: Genetics, stigma, and personal responsibility for women with eating disorders. *Social Science & Medicine*, 75(8), 1408–1416. doi:10.1016/j.socscimed.2012.05.042
- Egan, G., & Reese, R. J. (2018). *The skilled helper: A problem-management and opportunity-development approach to helping*. Boston, MA: Cengage.
- Ellis, C. (2004). *The ethnographic I: A methodological novel about autoethnography*. Walnut Creek, CA: AltaMira Press.
- Ellis, C. (2007). Telling secrets, revealing lives: Relational ethics in research with intimate others. *Qualitative Inquiry*, 13(1), 3–29. doi:10.1177/1077800406294947
- Ellis, C., Adams, T. E., & Bochner, A. P. (2011). Autoethnography: An overview. *Historical Social Research*, 36(4), 273–290.

- Ellis, C. & Bochner, A. P. (2000). Autoethnography, personal narrative, reflexivity. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp.733–768). Thousand Oaks, CA: Sage
- Ellis, C. S., & Bochner, A. P. (2006). Analyzing analytic autoethnography: An autopsy. *Journal of Contemporary Ethnography*, 35(4), 429–449.
doi:10.1177/0891241606286979
- Elzen, K. V. (2018). *The sport body image project: Exploring body image among athletes in Newfoundland and Labrador* (Master's thesis): Memorial University of Newfoundland; St John's; NL. Retrieved from <https://research.library.mun.ca/13482/>
- Fichter, M. M., & Quadflieg, N. (2016). Mortality in eating disorders – results of a large prospective clinical longitudinal study. *International Journal of Eating Disorders*, 49(4), 391–401. doi:10.1002/eat.22501
- Gattario, K. H., Frisé, A., Fuller-Tyszkiewicz, M., Ricciardelli, L. A., Diedrichs, P. C., Yager, Z., & Smolak, L. (2015). How is men's conformity to masculine norms related to their body image? Masculinity and muscularity across Western countries. *Psychology of Men & Masculinity*, 16(3), 337–347. doi:10.1037/a0038494
- Gibbs, R. W., & Franks, H. (2002). Embodied metaphor in women's narratives about their experiences with cancer. *Health Communication*, 14(2), 139–165.
doi:10.1207/s15327027hc1402_1
- Gillard, S., Foster, R., & Papoulias, C. (2016). Patient and public involvement and the implementation of research into practice. *Journal of Mental Health Training, Education and Practice*, 11(4), 256–267. doi:10.1108/jmhtep-02-2016-0014

- Gillard, S., Turner, K., & Neffgen, M. (2015). Understanding recovery in the context of lived experience of personality disorders: A collaborative, qualitative research study. *BMC Psychiatry*, 15(183). doi:10.1186/s12888-015-0572-0
- Gilpin, J. (2018, November 28). Why “reality apathy” is the next battle in brand reputation. *Adapt*. Retrieved from <https://sproutsocial.com/adapt/reality-apaty-brand-reputation/>
- Gladding, S. T. (2018). *The counseling dictionary* (4th ed.). Alexandria, VA: American Counseling Association.
- Gordon, A. R., Austin, S. B., Krieger, N., White Hughto, J. M., & Reisner, S. L. (2016). “I have to constantly prove to myself, to people, that I fit the bill”: Perspectives on weight and shape control behaviors among low-income, ethnically diverse young transgender women. *Social Science & Medicine*, 165, 141–149. doi:10.1016/j.socscimed.2016.07.038
- Grahl, G. A. (2007). *Skinny boy: A young man’s battle and triumph over anorexia*. Clearfield, UT: American Legacy Media.
- Griffiths, S., Costa, D. S., Boyd, J. E., Murray, S. B., Mitchison, D., & Mond, J. M. (2016). Facilitating research on eating disorders stigma: Validation of the Internalized Stigma of Mental Illness Scale for use in people with eating disorders. *Advances in Eating Disorders*, 4(3), 293–308. doi:10.1080/21662630.2016.1202125
- Griffiths, S., Mond, J. M., Li, Z., Gunatilake, S., Murray, S. B., Sheffield, J., & Touyz, S. (2015). Self-stigma of seeking treatment and being male predict an increased likelihood of having an undiagnosed eating disorder. *International Journal of Eating Disorders*, 48(6), 775–778. doi:10.1002/eat.22413

- Grimshaw, J. M., Eccles, M. P., Lavis, J. N., Hill, S. J., & Squires, J. E. (2012). Knowledge translation of research findings. *Implementation Science*, 7(50). doi:10.1186/1748-5908-7-50
- Håman, L., Barker-Ruchti, N., Patriksson, G., & Lindgren, E. (2015). Orthorexia nervosa: An integrative literature review of a lifestyle syndrome. *International Journal of Qualitative Studies on Health and Well-being*, 10(1), 26799. doi:10.3402/qhw.v10.26799
- Himmel, S., & Himmel, L. (2009). *Hungry: A mother and daughter fight anorexia*. New York, NY: Berkley Books.
- Holmes, S. (2014). Between feminism and anorexia: An autoethnography. *International Journal of Cultural Studies*, 19(2), 193–207. doi:10.1177/1367877914561831
- Hughes, S., Pennington, J. L., & Makris, S. (2012). Translating autoethnography across the AERA standards. *Educational Researcher*, 41(6), 209–219. doi:10.3102/0013189X12442983
- Johnston, J., Shu, C. Y., Hoiles, K. J., Clarke, P. J., Watson, H. J., Dunlop, P. D., & Egan, S. J. (2018). Perfectionism is associated with higher eating disorder symptoms and lower remission in children and adolescents diagnosed with eating disorders. *Eating Behaviors*, 30, 55–60. doi:10.1016/j.eatbeh.2018.05.008
- Jones-Smith, E. (2014). *Theories of counseling and psychotherapy: An integrative approach* (2nd ed.). London.UK. SAGE.
- Joseph, S., & Murphy, D. (2012). Person-Centered approach, positive psychology, and relational helping. *Journal of Humanistic Psychology*, 53(1), 26–51. doi:10.1177/0022167812436426

- Lavender, J. M., Brown, T. A., & Murray, S. B. (2017). Men, muscles, and eating disorders: An overview of traditional and muscularity-oriented disordered eating. *Current Psychiatry Reports, 19*(32). doi:10.1007/s11920-017-0787-5
- Lee, J., & Macdonald, D. (2010). 'Are they just checking our obesity or what?' The healthism discourse and rural young women. *Sport, Education and Society, 15*(2), 203–219. doi:10.1080/13573321003683851
- Maggio, L. M. (2014). Privileging the clients voice in a counseling psychology doctoral program. *Journal of Systemic Therapies, 33*(4), 35–46. doi:10.1521/jsyt.2014.33.4.35
- Marques, L., Alegria, M., Becker, A. E., Chen, C., Fang, A., Chosak, A., & Diniz, J. B. (2010). Comparative prevalence, correlates of impairment, and service utilization for eating disorders across US ethnic groups: Implications for reducing ethnic disparities in health care access for eating disorders. *International Journal of Eating Disorders, 44*(5), 412–420. doi:10.1002/eat.20787
- Mcilveen, P. (2008). Autoethnography as a method for reflexive research and practice in vocational psychology. *Australian Journal of Career Development, 17*(2), 13–20. doi:10.1177/103841620801700204
- Mcphail, G. (2015). The fault lines of recontextualisation: The limits of constructivism in education. *British Educational Research Journal, 42*(2), 294–313. doi:10.1002/berj.3199
- McPhee, L. (Producer & Director). (December 12, 2000). Dying to be thin [Transcript of television series episode]. In Twin Cities Public Television (Producer), *Nova*. Boston, MA: PBS. Retrieved from <https://www.pbs.org/wgbh/nova/video/dying-to-be-thin>

- Mehler, P. S., & Andersen, A. E. (2017). *Eating disorders: A guide to medical care and complications* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.
- Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation* (4th ed.). San Francisco, CA: Jossey-Bass.
- Missbach, B., Dunn, T. M., & König, J. S. (2017). We need new tools to assess orthorexia nervosa. A commentary on “Prevalence of orthorexia nervosa among college students based on Bratman’s Test and associated tendencies.” *Appetite*, 108, 521–524.
doi:10.1016/j.appet.2016.07.010
- Mitchison, D., & Mond, J. (2015). Epidemiology of eating disorders, eating disordered behaviour, and body image disturbance in males: A narrative review. *Journal of Eating Disorders*, 3(20). doi:10.1186/s40337-015-0058-y
- Moncrieff-Boyd, J. (2016). Anorexia nervosa (apepsia hysterica, anorexia hysterica), Sir William Gull, 1873. *Advances in Eating Disorders*, 4(1), 112–117.
doi:10.1080/21662630.2015.1079694
- Niedzielski, A., Kaźmierczak, N., & Grzybowski, A. (2016). Sir William Withey Gull (1816–1890). *Journal of Neurology*, 264(2), 419–420. doi:10.1007/s00415-016-8250-8259
- O’Brien, K. M., Whelan, D. R., Sandler, D. P., Hall, J. E., & Weinberg, C. R. (2017). Predictors and long-term health outcomes of eating disorders. *PLoS ONE*, 12(7).
doi:10.1371/journal.pone.0181104
- National Eating Disorder Association. (n.d.). [Home page]. Retrieved January 20, 2019, from <https://www.nationaleatingdisorders.org>
- National Eating Disorder Information Centre. [Home page]. Retrieved February 10, 2019, from <http://nedic.ca>

- National Eating Disorder Information Centre [NEDIC]. (n.d.). [Facebook group page]. Retrieved January 23, 2019, from https://www.facebook.com/pg/thenedic/photos/?ref=page_internal
- National Eating Disorder Information Centre [@the_nedic]. (n.d.). [Home page in NEDIC Instagram account]. Retrieved February 3, 2019, from https://www.instagram.com/the_nedic
- Pacheco, I. (January 9, 2012). The stages of change (Prochaska & DiClemente, 1983) [Blog post]. January 9, 2012. Retrieved February 3, 2019, from <http://socialworktech.com/2012/01/09/stages-of-change-prochaska-diclemente/>
- Papadopoulos, F. C., Ekbom, A., Brandt, L., & Ekselius, L. (2009). Excess mortality, causes of death and prognostic factors in anorexia nervosa. *British Journal of Psychiatry*, 194(1), 10–17. doi:10.1192/bjp.bp.108.054742
- Peterson, T. (2006, March 10). Dennis Quaid: I battled anorexia. *People*. Retrieved from <https://people.com/celebrity/dennis-quaid-i-battled-anorexia/>
- Pettersen, G., Wallin, K., & Björk, T. (2016). How do males recover from eating disorders? An interview study. *BMJ Open*, 6(8). doi:10.1136/bmjopen-2015-010760
- Philpot, D. (1995). *More than mere vanity: Men with eating disorders* (Master's thesis). Memorial University of Newfoundland, St. John's, NL. Retrieved from <https://research.library.mun.ca/6536/3/DavidFPhilpott.pdf>
- Pope, H., Phillips, K. A., & Olivardia, R. (2000). *The Adonis complex: The secret crisis of male body obsession*. New York, NY: Simon & Schuster.

- Räisänen, U., & Hunt, K. (2014). The role of gendered constructions of eating disorders in delayed help-seeking in men: A qualitative interview study. *BMJ Open*, 4(4). doi:10.1136/bmjopen-2013-004342
- Rance, N., Moller, N. P., & Clarke, V. (2015). 'Eating disorders are not about food, they're about life': Client perspectives on anorexia nervosa treatment. *Journal of Health Psychology*, 22(5), 582–594. doi:10.1177/1359105315609088
- Randall, V. (2010). Feminism. In V. Lowndes, D. Marsh, & G. Stoker (Eds.), *Theory and methods in political science* (4th ed.; pp. 114–135). Basingstoke, UK: Palgrave Macmillan.
- Reas, D. L., & Stedal, K. (2015). Eating disorders in men aged midlife and beyond. *Maturitas*, 81(2), 248–255. doi:10.1016/j.maturitas.2015.03.004
- Redel, D. [Producer]. (2018, September 7). Most of what follows is true: Michael Crummey on writing and the relationship between fact and fiction [Audio file]. In *Ideas*. Retrieved from <https://www.cbc.ca/radio/ideas/most-of-what-follows-is-true-michael-crummey-on-writing-and-the-relationship-between-fact-and-fiction-1.4814202>
- Robinson, K. J., Mountford, V. A., & Sperlinger, D. J. (2012). Being men with eating disorders: Perspectives of male eating disorder service-users. *Journal of Health Psychology*, 18(2), 176–186. doi:10.1177/1359105312440298
- Rogers, C. R. (1995). *On becoming a person: A therapist's view of psychotherapy*. Boston, MA: Houghton Mifflin.
- Roosen, K. (2017). *Disordered eating and body dissatisfaction in women with physical disabilities: A mixed methods approach* (Doctoral dissertation). York University,

- Toronto, ON, Retrieved from https://yorkspace.library.yorku.ca/xmlui/bitstream/handle/10315/34296/Roosen_Kaley_M_2017_PhD.pdf?sequence=2&isAllowed=y
- Saukko, P. (2008). *The anorexic self: A personal, political analysis of a diagnostic discourse*. Albany, NY: State University of New York Press.
- Simpson, C. C., & Mazzeo, S. E. (2017). Attitudes toward orthorexia nervosa relative to DSM-5 eating disorders. *International Journal of Eating Disorders*, 50(7), 781–792. doi:10.1002/eat.22710
- Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating disorders in men: Underdiagnosed, undertreated, and misunderstood. *Eating Disorders*, 20(5), 346–355. doi:10.1080/10640266.2012.715512
- Surtees, R. (2009). Food for thought: Embodied slimness and nursing within an eating disorders unit. In H. Malson & M. Burns (Eds.), *Critical feminist approaches to eating disorders* (pp. 157–159). New York, NY: Routledge.
- Sweeney, A., Clement, S., Gribble, K., Jackson, E., Carr, S., Catty, J., & Gillard, S. (2019). A systematic review of qualitative studies of adults' experiences of being assessed for psychological therapies. *Health Expectations*. Advance online publication. doi:10.1111/hex.12844
- Thomas, J. J., & Schaefer, J. (2013). *Almost anorexic: Is my (or my loved one's) relationship with food a problem?* Center City, MN: Hazelden.
- Tilsen, J., & Mcnamee, S. (2014). Feedback Informed Treatment: Evidence-Based practice meets social construction. *Family Process*, 54(1), 124–137. doi:10.1111/famp.12111

- Tod, D., Edwards, C., & Cranswick, I. (2016). Muscle dysmorphia: Current insights. *Psychology Research and Behavior Management*, 9, 179–188.
doi:10.2147/prbm.s97z404
- Vancouver Canucks [canucks]. (2019, February 2). Break the silence [Tweet]. Retrieved February 3, 2019, from <https://twitter.com/canucks/status/833073630015741952>
- Walker, K. (1997). Cutting edges: Deconstructive inquiry and the mission of the border ethnographer. *Nursing Inquiry*, 4(1), 3–13. doi:10.1111/j.1440-1800.1997.tb00131.x
- White, M. (2007). *Maps of narrative practice*. New York, NY: W. W. Norton.
- Winslade, J., & Monk, G. (2007). *Narrative counseling in schools: Powerful & brief*. Thousand Oaks, CA:Corwin Press. doi:10.4135/9781483329321
- Witztum, E., Stein, D., Latzer, Y., & Kalian, M. (2016). Spiritual self starvation en-route to salvation. In Y. Latzer & D. Stein (Eds.), *Bio-psycho-social contributions to understanding eating disorders* (pp. 169–180). Cham, Switzerland: Springer International Publishing.
- Wong, Y. J., Ho, M. R., Wang, S., & Miller, I. S. (2017). Meta-analyses of the relationship between conformity to masculine norms and mental health-related outcomes. *Journal of Counseling Psychology*, 64(1), 80–93. doi:10.1037/cou0000176
- Wood, H. T. (2013). *The disappearing girl: A novel*. United States: Createspace.
- Yalom, I., & Lescz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books