Exploring men's experiences and understanding of binge eating disorder: An interpretative phenomenological analysis

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Abstract

Binge Eating Disorder (BED) appears to have a fairly equal prevalence in men and women. However, men with BED have been overlooked in research as studies have mainly focused on women. As a result, there appears to be a limited understanding of men's experiences and treatment needs of BED, including from a Counselling Psychology perspective. A qualitative study was undertaken to explore men's experiences and understanding of BED including their experiences in seeking, accessing and receiving treatment. Semi-structured interviews were carried out with six men who had a diagnosis of BED. Data was analysed using Interpretative Phenomenological Analysis resulting in four super-ordinate themes: the experience of BED; the process of understanding; the stigmatised male self and the experience of treatment. The experience of BED was described as a divergent experience of negative and positive facets, characterised by a futile struggle to control their eating. The men described living a constrained life with BED similar to living in an inescapable trap. In trying to make sense of their BED, the men discussed the function of BED in their lives and they compared BED to an addiction. The experience of BED in men encompassed feelings of isolation and stigma due to having what they perceived as a female and/or homosexual disorder. These men discussed their strong adherence to male stereotypes of masculinity and having BED was perceived as unacceptable and emasculating. The participants' struggles with treatment were emphasised as they sought to find unavailable support and received what they felt to be inadequate treatment care. The applicability of these findings for professional practice and Counselling Psychology practice are discussed and include exploring men's recommendations towards tailoring treatment to meet their needs, for example all-male group therapy and addressing masculinity and stigma.

Chapter 1

Introduction

Overview

The purpose of this research is to explore men's experiences and understanding of Binge Eating Disorder (BED). This chapter will briefly introduce the study and provide an overview of the organisation of the research followed by a reflexive statement.

BED and Men

Eating disorders (EDs) are predominantly associated with women as they are more prevalent in women than men (Striegel-Moore, 1995). This skewed prevalence distribution has led to EDs being considered as a 'female phenomenon' (Robinson, Mountford & Sperlinger, 2013). However, men do suffer from EDs. It is estimated that 1.6 million people in the UK have an ED, of which 11% are men (National Institute for Health and Care Excellence, NICE, 2004). BED is found to be the most common ED in the general population (Hudson, Hiripi, Pope & Kessler, 2007) and to affect fairly equal numbers of men and women (Muise, Stein & Arbess, 2003). BED is characterised by recurrent episodes of unusual large amount of food consumption accompanied by distress and loss of control over eating (Mitchell, Devlin, de Zwaan, Crow & Peterson, 2008). In 1959, Albert Stunkard first described the characteristics associated with BED through his clinical observations of obese individuals who engaged in recurrent binge eating with no subsequent compensatory behaviour (Stunkard, 1959). Since then, most research studies have explored BED in women only, despite the high prevalence of BED in men. As a result, BED and men remains a relatively under-researched area.

Research, clinical guidelines and an understanding of the treatment needs of men with BED appears to be limited, including from a Counselling

Psychology (CoP) perspective. As a result, there is a dearth of knowledge to support the work of clinicians working in this field.

Organisation of the research study

Chapter 2 provides a review of the existing research in the area of BED and men, where the theoretical framework and empirical data will be reviewed and critically evaluated. Additionally, the current study's contribution and applicability in the field of EDs and CoP will be presented before outlining the research question. Chapter 3 presents the methodology of the study and describes the procedures of the research in relation to sampling, recruitment, data collection and analytic process. Chapter 4 presents the findings and themes that emerged from analysis of the data. An overall discussion of the research findings is provided in Chapter 5, by contextualising them within the context of existing literature, while considering the limitations of the study and suggestions for future research. Additionally, it will consider the applicability of the findings to CoP and to professional practice in the area of men with BED.

Reflexive statement

Reflexivity examines how the researcher can influence the research process (Finlay, 2002a). As Flood (1999) argues, 'without some degree of reflexivity any research is blind and without purpose' (p.35). I therefore begin by making my assumptions and experiences in relation to the topic area explicit in order to situate myself with respect to the research and to enhance the research's rigour (Willig, 2001). I view research as embarking on a constantly moving and never fixed journey, a journey of becoming and transforming (Etherington, 2004). As a counselling psychologist researcher, I believe it is important to remain open to complexities, to work with uncertainty and most importantly to learn. In many ways, this research is my learning journey, my journey of 'becoming a researcher'.

My cultural background has had a great impact on my decision to carry out research in EDs. I come from a Mediterranean country with an extremely hot

climate which means exposing one's physique to a great extent. Food, weight and appearance are an intrinsic part of people's lives. I have witnessed friends measuring their lunch in a cup and drinking vinegar to dissolve the fats they consumed. No one considered the idea of achieving thinness at any cost to be wrong and no one ever challenged it. My personal experiences led to the assumption that EDs occur in adolescence, an assumption which might have resulted in conducting research in only this age group. Had I not acknowledged such presupposition, I would have failed to include men of all ages in my research, as EDs occur irrespective of age, culture and gender.

I grew up in a small coastal village and in an even smaller and closed society, where feelings are considered a weakness reserved for women, not men. My experiences have shaped my beliefs that men do not express their emotions and deal with their problems in a different way than women. I had to be mindful of my gender-behaviour assumptions as I was inclined to view men with BED as not willing to share their experiences, which impacted the initial interview schedule drafts. As Kasket (2012) argues, it is imperative to become aware of one's assumptions and beliefs in order to adequately explore them when conducting research as a counselling psychologist.

In order to manage the researcher's impact on the research process I implemented a number of reflexive practices (Kasket, 2013; Smith, Flowers & Larkin, 2009). I kept a reflective journal throughout the research which enabled me to explore my presuppositions and bracket them in order not to let them impinge on the research process. I made careful use of supervision, peer sessions and attended the IPA regional research group meetings.

My interest in EDs continued to expand through my undergraduate and postgraduate studies. I had immersed myself in reading about EDs, even taking up EDs modules which unfortunately focused only on women. During my doctoral studies I wished to deepen my understanding of men and EDs through research and clinical practice. While discussing my novel research ideas I encountered dismissive comments from peers training in different areas of psychology 'why would you want to research men and eating disorders? Men don't get eating disorders!' The more barriers I found, the more passionate I became about conducting research on men and EDs.

Reading about EDs I came across BED, a devastating example of an ED characterised by the need to eat excessively accompanied by feelings of guilt and shame. My final decision to carry out research in men with BED came through researching existing literature which proved to have a notable gap in the area of men and BED. This area appeared to have been under-researched by CoP as well.

At the time of developing my research ideas I was working for a specialised EDs service as a trainee counselling psychologist. I had only seen female clients with EDs and in considering the possibility of having a male client with an ED, I was unsure as to what to do in my practice. Returning to the literature, I found little information for professional practitioners and counselling psychologists in providing treatment for men with EDs and even less information on men with BED. This further fuelled my personal and professional zeal to conduct research on men with BED, as from a CoP perspective it is imperative to produce research that will inform practice and 'will ultimately make a positive difference in people's lives' (Kasket, 2012, p.68).

As the subjectivity of the researcher is 'imposed at all stages of the research process' (Hertz, 1997, p.viii), I will engage with reflexivity throughout the research. The first person will be adopted in the reflexivity sections in order to remain close to the researcher's account and personal experiences.

Chapter 2

Literature Review

Overview

This chapter will present the relevant clinical, theoretical and empirical literature on BED and EDs in men. A broad description of what constitutes BED in terms of definition and prevalence will be provided, followed by a discussion of a theoretical framework selectively constructed for this research study by drawing on relevant areas of theoretical literature. Then, specific areas associated with men with EDs will be considered such as muscularity and sexuality. The existing literature on BED will then be explored including the research studies focusing on gender differences in BED. Next, the relevant clinical and empirical literature on treatment issues in men with EDs and BED will be presented including a consideration of psychological treatments and men's experiences of seeking and receiving treatment. Finally, this review will lead to the identification of a number of gaps in the existing knowledge base of BED in men and will conclude with the specific research aims and research question the present study seeks to address.

Binge Eating Disorder

Definition

BED is defined as recurrent uncontrollable episodes of binge eating during which one consumes large quantities of food, while experiencing marked distress, guilt or disgust during or after the eating binge and loss of control over eating (Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-V), American Psychiatric Association (APA), 2013). BED has been associated with high health risks such as obesity and diabetes (Heinberg, Thompson & Matzon, 2001). BED has also been found to have high co-morbidity with psychological problems, for example depression and anxiety (Womble et al., 2001).

In the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994) there were three ED diagnostic categories: Anorexia Nervosa (AN), Bulimia Nervosa (BN) and Eating Disorders Not Otherwise Specified (EDNOS). BED was introduced in 1994 in DSM-IV as a residual category within EDNOS in need of further research. Since the publication of the newest edition of the DSM-V in May 2013, BED has been classified as a distinct ED diagnostic category. This decision was informed by accumulation of scientific evidence supporting the construct validity of BED as a diagnostic category (Striegel-Moore & Franko, 2008).

BED shares similar features with AN and BN, which is known as the 'core psychopathology' of EDs (Fairburn, 2008). This refers to the over-evaluation of shape and weight and their control which is present in all EDs. BED is similar to BN as binge eating is present in both EDs. However, individuals with BN engage in purging behaviours such as vomiting or using laxatives as weight compensatory behaviours. Such behaviours are absent in BED, as individuals do not engage in any purging behaviours (Wilfley, Wilson & Agras, 2003).

There are a number of controversies and problems in the diagnosis of EDs in the DSM classification scheme. For example, there is cumulative evidence of diagnostic overlap and crossover between EDs which challenges the validity of the existing diagnostic categories as specified by the DSM (Fichter & Quadflieg, 2007; Wilfley, Bishop, Wilson & Agras, 2007). There is also a longstanding debate over the use of diagnostic systems in CoP (Eriksen & Kress, 2006; Larsson, Brooks & Loewenthal, 2012). The diagnostic systems have long being considered as not having a place within CoP as the classification of symptoms does not adhere to the profession's philosophical lay stone of respecting and valuing each individual's idiosyncratic experiences (British Psychological Society (BPS), 2005; Orlans & van Scoyoc, 2009). The DSM focuses on the symptomatology of disorders and on the negative aspects of individuals' functioning and fails to incorporate idiosyncratic, cultural, and developmental factors in the diagnosis. Furthermore, CoP values individual diversity and is firmly based on the humanistic values of non-pathologising and using labels to describe individuals' difficulties (Lane & Corrie, 2006; Larsson et al., 2012).This issue will next be addressed in the discussion chapter.

Epidemiology

BED has been found to be at least as common as AN and BN in the general population as it affects approximately 3% to 5% of the general population (Machado, Machado, Goncalves & Hoek, 2007), whereas the prevalence of AN and BN appears to affect between 1% and 4% (Fairburn & Harrison, 2003; Hoek & van Hoeken, 2003). More recently, in a population-based estimate of the prevalence of BED among adults across 14 countries, Kessler et al. (2013) found BED to be at least equal to BN, with a lifetime prevalence of 1.4% for BED and 0.8% for BN.

Studies have shown a higher prevalence of EDs among women than in men. Hudson et al. (2007), in a USA National Comorbidity study, found the lifetime prevalence rates for women to be 0.9 for AN and 1.5 for BN and for men to be 0.3 for AN and 0.5 for BN. Similar prevalence rates were found in studies across Europe (Jacobi et al., 2004; Wittchen & Jacobi, 2005). Currin, Schmidt and Waller (2007) conducted a study on incidence rates in the UK and found a 12:1 risk for AN for females to males and a 18:1 risk for BN. This skewed gender distribution has strongly associated EDs with girls and women (de Beer & Wren, 2012). Possible explanations that have been proposed for the gender discrepancy in EDs include the socio-cultural pressures on women to be thin (Stice, 1994) and the fact that women are more likely to seek treatment than men (Lewinsohn, Seeley, Moerk & Striegel-Moore, 2002).

Epidemiological studies on BED amongst men and women have shown that there is a less pronounced gender difference in BED, as studies have shown a 3:2 female to male ratio (Smith, Marcus & Eldredge, 1994). Similarly, other findings show that BED is as common in men as in women (Lewinsohn et al., 2002; Smolak &Murner, 2001; Striegel-Moore et al., 2009) and that men represent up to 40% of cases of BED (Muise et al., 2003). Possible explanations proposed for the less pronounced gender difference in BED suggest that men are more likely than women to binge eat than restrict food as it is socially more acceptable for men to eat large quantities of food (Jones & Morgan, 2010). However, the factors which determine the gender discrepancy in BED remain unclear.

Eating behaviours in BED

In their book 'Eating Disorders', Kirkpatrick and Caldwell (2001) discuss their clinical experience of working with individuals with BED. They describe how individuals feel guilt and disgust after a binging episode where they experience loss of control over their food consumption and even dissociation from their surroundings. In his book 'Overcoming Binge Eating', Christopher Fairburn, a psychiatrist conducting research and clinical work in EDs in the UK, describes how binge eating and obsessing over food serve as dissociations from intense affect present in an individual's life. He also describes how individuals suffering from BED tend to eat in secrecy, avoid social situations where eating is involved and hide any evidence of their food consumption (Fairburn, 1995; 2013).

Risk factors

Most studies exploring the possible risk factors involved in the development of BED have been conducted on women. Fairburn et al. (1998) in a community based study in the UK found that adverse childhood experiences (sexual/physical abuse or bullying), family problems, negative self-evaluation, shyness and vulnerability to obesity are all considered risk factors for women developing BED. Additionally, family overeating and childhood obesity (Striegel-Moore et al., 2005); exposure to critical comments about shape, weight or eating, major changes in life circumstances and stress (Pike et al., 2006), have also been found to be risk factors in women developing BED. The risk factors involved in men developing EDs, including BED, have been found to be exercise and athletic competition (Sundgot-Borgen & Torstveit, 2004; Weltzin et al., 2005), alcoholism, history of obesity, teasing and physical abuse (Johnson, Cohen, Kasen & Brook, 2002; Striegel-Moore, Garvin, Dohm & Rosenheck, 1999; Tanofsky, Wilfley, Spurrell, Welch, Brownell, 1997). As such, the possible risk factors specifically involved in the development of BED in men remain unclear.

Theoretical Framework

In the following section a theoretical framework for the study of BED will be presented. This is not an exhaustive review of existing psychological theories on BED, but a selective presentation of those theories that have particular relevance to the current study and are considered to specifically address binge eating in BED. It is acknowledged that the selection of these theories might have been influenced by the researcher's training and clinical practice experience. There are a number of other theories addressing binge eating which have not been included here, for example attachment theory (Pearlman, 2005), second-skin formation (Reilly, 2004), trade-off theory (Kenardy, Arnow & Agras, 1996) and masking theory (Polivy & Herman, 1999).

There is no one particular theoretical model specifically outlined in the clinical guidelines available for EDs (e.g. NICE, 2004; Royal College of Psychiatrists, 2000; 2012). Among various theoretical models, it appears that there is accumulation of evidence in support of the affect regulation model for understanding the function of binge eating (Deaver, Miltenberger, Smyth, Meidinger & Crosby, 2003; Rosenbaum & White, 2013; Telch & Agras, 1996), which will be explored below.

Affect regulation model

According to the affect regulation model, binge eating occurs in order to alleviate negative mood, provide distraction from negative emotional states and provide temporary comfort (Polivy & Herman, 1993). There are a number of theories that fall under the affect regulation model as they focus on the role of affect in binge eating, for example escape theory.

The escape model of binge eating suggests that binge eating is a motivated attempt to escape from aversive self-awareness (Heatherton & Baumeister, 1991). The model suggests that individuals who binge have high levels of self-awareness and set high expectations for themselves and what others expect from them. These might include goals or perceived expectations for achievement and body thinness. When individuals are not able to meet such unattainable standards they develop views of themselves as inadequate and

deficient and show aversive self-awareness. The model suggests that in order to escape from such an unpleasant state, individuals engage in cognitive narrowing where they focus on present and immediate stimuli and avoid any broad meaningful thinking. This cognitive narrowing leads to the removal of inhibitions regarding eating and 'fosters an uncritical acceptance of irrational beliefs and thoughts' (p.86). As normal patterns of eating are suspended, irrational thoughts occur creating a 'mental vacuum'. In escaping from one's own self and self-awareness, the individual then engages in binge eating.

Cognitive Behavioural Theories

The cognitive behavioural model of binge eating suggests that binge eating occurs due to excessive body shape and weight concerns, and where the evaluation of shape and weight are central to individuals' self-esteem. Impossible strict rules around eating govern individuals' eating habits, and any perceived violation of these rules leads to binge eating. A vicious cycle is formed in which binge eating is followed by extreme dieting and/or restriction of food which further exacerbates the extreme weight and shape concerns. This in turn reinforces the ED behaviours and binge episodes (Mitchell et al., 2008).

The Cognitive Behavioural Therapy model (CBT) for BED has been adopted from the CBT model for BN (Fairburn, Marcus & Wilson, 1993). Moreover, there are various adaptations of the CBT model for individuals with BED (Devlin, 2001; Marcus, 1997; Mitchell et al., 2008); including an enhanced CBT (CBT-E) transdiagnostic model developed by Christopher Fairburn (2008).

Restraint theory

Restraint theory postulates that dieting or restraining food is a causal factor in BED (Howard & Porzelius, 1999). When an individual is dieting there is a shift in eating behaviours from physiological to cognitive control. When such cognitive processes are disturbed, for example by the consumption of a forbidden type of food, the individual becomes more vulnerable to disinhibited eating and to binge eating (Polivy & Herman, 1999). This also relates to engaging in binge eating because of a perceived violation of strict dietary rules which results in temporarily abandoning any diet and dietary restraint, thus activating an all-or-

nothing thought pattern known as the 'abstinence violation effect' (Spoor et al., 2006). This extreme thinking elevates negative moods and any attempts to exert control over eating fail, leading to binge eating (Grilo & Shiffman, 1994). According to restraint theory, prolonged dieting and/or restriction of food increases the risk of binge eating (Polivy & Herman, 1999). A number of studies reveal discrepant findings on the adequacy of restraint theory, as individuals with BED have been found to engage in binge eating before dieting (Manwaring et al., 2006; Mussell et al., 1995).

Addiction model

The addiction model of EDs conceptualises binge eating as food addiction and views certain foods as toxic which the individual needs to abstain from (Ronel & Libman, 2003; Wilson, 1991). Research studies reveal conflicting evidence of the adequacy of the addiction model in EDs. Davis and Carter (2009) provided evidence in support of significant similarities between BED and drug addiction, conceptualising BED as an addictive behaviour. They argue that loss of control is a feature shared by both BED and drug abuse. For example, drug abuse is characterised by an increasing compulsion to use drugs despite knowledge of adverse effects on health. Similarly, BED is characterised by repetitive binge eating despite knowledge of adverse effects on health and weight. Similarly, Cassin and von Ranson (2007) found a number of similarities between binge eating and addiction. They looked at whether binge eating is experienced as an addiction in women with BED and found that 94% described themselves as 'food addicts' or 'compulsive overeaters'. However, the researchers concluded that BED should not be regarded as an addiction disorder, as individuals may or may not experience their BED as an addiction.

Men and Eating Disorders

In this section literature regarding EDs in men will be reviewed in order to present men's specific views on having an ED and to address issues specifically associated with men with EDs.

Men's views on having an eating disorder

A number of studies have specifically investigated men's experiences of EDs. Narrative literature reviews of EDs in males show that men experience embarrassment and stigma as EDs are perceived to be 'female diseases'(Andersen, 1999; Jones & Morgan, 2010; Rosen, 2003). Similarly, qualitative studies exploring the experience of men with AN and/or BN suggest that men consider EDs to be a feminised phenomenon which makes them feel 'less masculine or flawed' (Drummond, 2002) and 'less than male' (de Beer, 2009). It has been suggested that such views may inhibit men from seeking treatment (Andersen, 1999), an issue which will be addressed in the treatment section (p.28).

Muscularity and Body image

Over the past decade there has been a heightened interest in researching body image in men across different countries, including the USA, UK, Australia, France and Austria (Augustine, 2010; Murray, Rieger, Karlov & Touyz, 2013; Olivardia, Pope, Borowiecki & Cohane, 2004; Pope et al., 2000). Research findings suggest that men in the Western culture idealise a slender muscled physique with well-developed muscles on their chests, arms and shoulders; rather than a thin physique, more pertinent to women (Cafri et al., 2005; Leit, Gray & Pope, 2002). Additionally, thinness does play a role in male physique as low body fat enables muscles to be more visible (Cafri & Thompson, 2004). Striving to achieve a male muscular ideal has been termed as the 'drive for muscularity' (McCreary & Sasse, 2000). Olivardia and colleagues (2004) have found body dissatisfaction and drive for muscularity in men to be associated with low body esteem, depression and ED symptoms. Male athletes have been found to be vulnerable to EDs and body dissatisfaction due to the pressures of risky weight loss/gain practices required to achieve weight limits in sports (Petrie & Rogers, 2001).

Sexuality

Sexuality, another area associated with EDs and men, is an area of considerable debate. Research suggests that homosexual men are at greater risk

of developing body image dissatisfaction and EDs than heterosexual men (Boroughs & Thompson, 2002; Williamson, 1999). Possible explanations addressing this discrepancy include the emphasis placed on appearance and body physique by the gay community which gay men might find difficult to conform to (Feldman & Meyer, 2007). Another explanation relates to the greater exposure to and consumption of pornography found in homosexual than heterosexual men. The pornographic exposure in the gay community may set the standards for an idealised male physique which men might believe they need to possess in order to be sexually attractive (Duggan & McCreary, 2004).

Additionally, research studies have suggested a high prevalence of men seeking treatment (20-33%) to be homosexual (Andersen, 1999; Strong, Williamson, Netemeyer & Geer, 2000). However, these studies have been criticised on a number of grounds; for example, only a small number of men in these studies would meet the criteria for EDs diagnosis and several studies combined homosexual and bisexual men to produce a large sample to compare against heterosexual males (Kane, 2010). Research studies in EDs remain divided as to whether homosexuality is associated with men with EDs (Bramon-Bosch, Troop & Treasure, 2000; Robinson et al., 2013). To date, no research study has specifically explored the issues of muscularity, sexuality, body image and dissatisfaction in men with BED, making this an area in need of further research.

Gender differences in EDs

Research suggests similarities between men and women who struggle with EDs, for example psychiatric comorbidity (Woodside et al., 2001). However, important differences and unique issues pertinent to men with EDs have been suggested for example isolation, stigmatisation, masculine identity, gender role conflict and emasculation (Andersen & Holman, 1997; Weltzin et al., 2005).

Greenberg and Schoen (2008) conducted a review of empirical findings in EDs and found a number of important gender differences. One such difference is the issue of stigma. Both men and women may experience stigma in admitting to having an ED. However, men may face additional stigma, shame and embarrassment in admitting to having a disorder that is commonly associated

with women (Carlat, Camargo & Herzog, 1997). Another gender difference relates to masculinity in men. Masculinity can have a negative impact on men's help-seeking attitudes towards seeking treatment for an ED as this may be perceived to be inconsistent with masculinity ideals (Mahalik, Good & Englar-Carlson, 2003).

More recently, in an EDs survey study, Strother, Lemberg, Stanford and Turberville (2012) identified a number of gender-specific issues in which men and women with EDs differ; for example weight history, exercise and body image, co-morbid chemical dependency. The researchers concluded that there is a great need for more research to focus on men and EDs and on their gender-specific needs 'in order to better understand and treat them successfully' (p.347).

BED in men and women

In this section the existing literature in BED will be explored in detail including a review of gender differences research in BED.

Existing Literature in BED

Research into individuals' subjective experiences associated with BED has been scarce and only conducted on women. The majority of research on BED focuses on the etiology, symptoms, diagnosis and treatment of BED based primarily on women (Hudson et al., 2010; Masheb & Grilo, 2006). The information available to understand individuals' experiences of BED has evolved from research on binge eating in BN, research on binging and purging behaviours and from quantitative studies on BED with a majority of female participants. In contrast, there have been EDs research studies conducted using qualitative methods exploring AN and BN in women (McNamara, Chur-Hansen & Hay, 2008; Spivak, 2010) and in men (Burns & Crisp, 1990; Copperman, 2000; de Beer, 2009; Drummond, 1999; 2002).

Searches conducted for the present review using ISI Web of Knowledge, PsychINFO databases and in specific journals such as International Journal of Eating Disorders and Counselling Psychology Review found one male case report on BED (Chen & Tao, 2010) and three studies exploring women's

experiences with BED (Owens, 2003; Sandy, 2006; Starkman, 2005). The studies found on women come from three unpublished USA doctoral theses from different disciplines; counsellor education, educational psychology and social work. The case report and theses will be reviewed in detail below. No known published or unpublished research has been found that specifically explores the experiences of men with BED, indicating that this remains a neglected research area.

To date, the only research study addressing BED in men is a case report of a 21-year-old Chinese male with BED (Chen & Tao, 2010). The authors set out to describe the history, symptoms and treatment of the individual's BED. Even though this study is an important contribution to the literature of men with BED as it raises awareness of the issue of BED in men in China, it suffers from a number of limitations. The authors do not discuss how BED was identified or diagnosed and only provide a brief description of the client's eating habits. There is no reference to the client's experiences with BED and it appears that the client attended counselling to address his relationship break-up. The authors argue that the client 'did not reveal the trouble of his binge eating' (p.155) during counselling and offer their personal speculations about what they think were the reasons behind the client's struggles with BED. The authors' main argument does not focus on the issue of BED or EDs in men; it rather focuses on the urbanisation process in China which, as they argue, causes many psychological problems. Furthermore, this study does not explore any clinical implications significant to professional practice and to counselling psychologists working with men with BED.

Owens (2003) examined how six women experienced BED in a qualitative study using grounded theory. Owens specifically investigated women's experiences because, as she argued, women are more likely to exhibit EDs than men. Participants described experiencing loss of control and feeling unable to stop eating during binge episodes. The women also described associating food with providing comfort from negative feelings such as loneliness and stress and in experiencing feelings of dissociation during binge eating. The women also expressed the physical and emotional consequences of binge eating as feeling guilt and disgust and worrying about the physical outcome of BED in weight gain and risk of obesity. However, some women

described how being overweight was considered to be a protective factor in not being physically attractive and therefore protecting themselves against sexual traumas, from which they had suffered in the past. Owens argues that further 'research is needed to determine how men experience this disorder and if their experiences are similar or different from women's' (p.214). It appears that there is no theoretical argument proposed in the literature to explain why men's experiences of BED may be similar to or different from women's experiences.

Similar to Owens (2003), Starkman (2005) conducted a grounded theory research examining 13 women's experiences with BED. The researcher did not outline a rationale for conducting research only on women. Participants described associating binge eating with providing them comfort and distraction from feelings of depression, loneliness and anxiety. They also described experiencing feelings of dissociation during the actual binge episode. These women described binge eating as having a self-regulation and self-soothing function as they experienced lack of nurturing and emotional support from their caregivers. BED was also described as a consequence from the traumatic experiences these women had gone through, for example bulling, sexual and physical abuse. Additionally, the women expressed what they understood to be the socio-cultural pressures for women to be thin in order to be beautiful as having an influence on their binge eating. For future research, Starkman suggested exploring the experiences of a more diverse sample group including gender in order to generalise findings to an overall population of individuals suffering from BED.

The third thesis by Sandy (2006) used a phenomenological approach to investigate the experiences of nine women with BED. The women in this study described having an emotional connection to food as they understood BED functioning as a coping mechanism from negative emotions. They also described experiencing loss of control over eating and engaging in secretive behaviours in order to carry out their binge eating. Additionally, the women described a strong sense of 'not fitting in' with other women and their family members because of their excess weight, eating habits and BED. Similar to Owens (2003), the rationale put forward to explore only women's experiences was due to the higher prevalence of EDs in women than in men. The researcher did highlight that looking only at women's experiences does not in any way diminish the

seriousness of BED in men. The researcher also recommended future research should focus on men's experiences with BED.

A limitation underlies these three theses as they are not available in the UK (except by online pre-payment) which means they are not readily accessible to practitioners in the UK and they are unable to inform professional practice. Moreover, the lack of research into men's experiences of BED further highlights the gap in the literature and contributes to the present study's rationale for the need of an in-depth exploration of men's experiences of BED.

Gender differences in BED

Reviewing the empirical evidence on BED, it is clear that research has mainly focused on women and not men. As the prevalence of BED appears to be fairly equal across genders, it is important to explore whether any gender differences exist in individuals with BED. The few studies that have focused on gender differences in BED have found that men and women do not differ on EDs features, developmental history or associated psychological distress (Barry, Grilo & Masheb, 2002; Tanofsky et al., 1997). However, notable differences have been found between women and men suffering from BED.

Barry and colleagues (2002) examined gender differences in 182 men and women with BED seeking treatment in an outpatient centre in the USA. The researchers used a battery of questionnaires to assess developmental, eating and weight-related disturbances and psychological features associated with BED. They found no differences in developmental variables, EDs features, depression or self-esteem between genders. However, they found body image dissatisfaction and drive for thinness to be greater in women than in men. They also found greater prior substance abuse and a higher BMI and obesity classification in men than women.

Tanofsky and colleagues (1997) compared 42 obese American men and women with BED using questionnaires on eating behaviours, psychopathology of EDs and psychological functioning. Similar to Barry et al. (2002), Tanofsky and colleagues did not find any gender differences related to developmental variables, eating features and self-esteem and found a greater history of substance abuse in men than women. In support of this finding, the researchers argue that substance abuse in men with BED is not surprising, as research shows greater substance

abuse in men than women. They also found men to have a greater history of comorbid Axis 1 psychopathology. The researchers argue that this finding may be related to men's reluctance to seek treatment for BED as it is associated with a 'female disorder'; men therefore experience greater distress than women. Moreover, they found a greater urge in women to cope with negative emotions by eating. Binge eating in response to negative affect has been reported elsewhere (Masheb & Grilo, 2006), providing support for the affect regulation model in BED.

Another study on gender differences in BED examined the relationship between shame, behavioural and attitudinal features in 188 treatment-seeking American individuals using a battery of questionnaires (Jamberkar, Masheb & Grilo, 2003). They found similar levels of shame experienced by men and women with BED. However, attitudinal differences were found as shame was associated with body dissatisfaction in men, whereas in women it was associated with their weight. These findings are supported by empirical evidence showing gender differences in what is regarded as an ideal body (Stanford & McCabe, 2002). Men have been found to idealise a muscular physique (Pope, Phillips & Olivardia, 2002) and to prefer a leaner and more muscular body than their own (Tiggemann, Martins & Kirkbride, 2007). On the other hand, women show greater preoccupation with their weight, idealising a thin body ideal.

A potential limitation to the Barry et al. study (2002) lies in the issue of sample biases. The researchers recruited an elevated female-to-male sample in their study as they included 147 females and 35 males. A similar sample bias was evident in the Jamberkar et al. (2003) study as they recruited 150 women and 38 men. Additionally, participants in both of these studies were treatment-seeking individuals, which further limit the studies' findings to only treatment-seeking individuals with BED.

Treatment

In this section, a review of the literature on issues associated with the treatment of BED and EDs in men will be provided, including treatment guidelines, psychological treatments and men's experiences of treatment.

Additionally, recommendations to professional practice in working with men with EDs will be reviewed which might be relevant to a wide range of professionals, for example counselling and clinical psychologists, specialist nurses, psychotherapists, psychiatrists and occupational therapists.

Treatment guidelines for EDs

There are a number of clinical guidelines and policies developed for individuals with EDs. However, these guidelines focus only on women and fail to provide any specific treatment recommendations for men with EDs. The National Institute for Health and Care Excellence (NICE, 2004) provides guidance and advice to improve health and social care in the UK, including guidance on the management and treatment of EDs in adults, children and adolescents. However, it does not include any treatment guidelines, or sufficiently emphasise the needs of men with EDs, suggesting that 'because eating disorders are less common in males, they can go undetected' (p.189). NICE guidelines make a brief reference to men's experiences of EDs, considering them to be 'primarily a female issue' which 'can make it more difficult for men to seek help' (p.39).

Three other important reports on the development of policies and services in EDs were published by the Royal College of Psychiatrists (2000; 2012) and the BPS (Bell, Clare & Thorn, 2001). These reports do not consider any treatment recommendations for men with EDs. Furthermore, the UK's largest EDs organisation, B-eat, commissioned a review of the provision of health care services for men with EDs concluding that 'there has been little exploration of the specific treatment needs for men' further highlighting problems with men accessing treatment services and the limited action being taken to address men's needs with EDs (Copperman, 2000). As a result, professionals who work with men with EDs are likely to be highly challenged due to the lack of specific treatment guidelines addressing men's needs.

Psychological treatments

A short review of research findings on the efficacy of treatments in BED will be presented. None of these studies specifically focus on men; rather they employ women as participants or men and women.

CBT is the recommended treatment choice for BED by NICE (2004) and has the strongest empirical support as found in randomised control trials (RCTs) (Munsch et al., 2007; Tasca et al., 2006). The efficacy of CBT is also supported by meta-analysis studies (Vocks et al., 2009) and current reviews (Brownley, Berkman, Sedway, Lohr & Bulik, 2007). However, CBT has received criticism for not demonstrating any efficacy in reducing weight loss in individuals with BED (Wilson & Fairburn, 2000).

Other treatment modalities which have been found to be effective in the treatment of BED include Dialectical Behaviour Therapy (Safer, Robinson & Jo, 2010; Telch, Agras & Linehan, 2001) and guided self-help based on CBT (CBTgsh) (Carter & Fairburn, 1998; Loeb, Wilson, Gilbert & Labouvie, 2000). Interpersonal Therapy (IPT) has been found to be as effective as CBT treatment for BED in RCTs over 1-year-follow up (Wilfley et al., 2002) and after 4-year-follow up (Hilbert et al., 2012). Moreover, in an RCT study Wilson, Wilfley, Agras and Bryson (2010) found a greater efficacy of either IPT or CBTgsh over behavioural weight loss at a 2-year-follow up in eliminating binge eating. Reviewing the empirical evidence in treatment efficacy, it appears that in the treatment of BED both genders receive the same treatment interventions regardless of the evidence supporting gender differences in BED (Barry et al., 2002).

Awareness and detection of BED by health care professionals

Professionals have been found to be less likely to identify EDs in men as they associate EDs with women, a belief reinforced by EDs prevalence studies (de Beer & Wren, 2012; Jones & Morgan, 2010). In a qualitative study, Henderson, May and Chew-Graham (2003) explored general practitioners' (GPs) awareness and knowledge of BED in the UK. They found that GPs were unaware of the existence of BED, in terms of diagnosis and management. Additionally, GPs were reluctant to diagnose obese individuals with BED due to the lack of specialised treatment services and effective management of BED. These findings

are alarming, since GPs 'form the primary pathway into medical care for sufferers' (p.301) and can greatly impact the effective detection and treatment of BED. Throughout the study, the researchers make references to BED in relation to women, giving the impression that BED affects only women. Additionally, GPs who did express some experience and knowledge of BED, did not specify whether their patients were male and/or female. It is therefore not possible to render any possible gender differences or similarities in the detection and treatment of BED in men and women. Despite these limitations, this research points to a considerable gap in professionals' knowledge regarding detection and treatment of BED. The current study seeks to address this gap by raising awareness in BED and men to inform professional practice.

Men's experiences of treatment

Five qualitative studies have been found to explore men's experiences of receiving treatment for EDs (Copperman, 2000; de Beer, 2009; Drummond, 1999, 2002; Robinson et al., 2013). Men were found to be dissatisfied with the treatment they received and wished for their 'maleness' to be recognised in treatment. However, none of these studies included men with BED in their samples. For example, de Beer (2009) explored nine men's experiences of AN and BN and their experiences in gaining access to treatment in the UK. This qualitative study is an unpublished doctoral thesis in clinical psychology and used IPA to analyse the data. Men expressed problems with identification, delayed referrals, the importance of specialist treatment and the importance of choice and motivation in treatment. This study did not include men with BED in the sample or provide a rationale for this exclusion. It is possible that de Beer's findings could possibly be generalisable to men with BED. However, given the lack of research evidence in men's experience of BED, a comparison cannot be made and de Beer's findings cannot be fully applied to men with BED.

More recently, Robinson et al. (2013) explored the experiences of eight men seeking and receiving treatment from two specialist EDs services in London. Using IPA, the researchers found that men had difficulties admitting to and disclosing the fact of having an ED due to the stereotype of EDs only affecting women. Participants expressed the importance of feeling understood and cared

for by professionals, and expressed differing views on whether gender was an issue in treatment. For example, some participants described how men and women face similar challenges in treatment and suggested gender was irrelevant as each person is an individual with unique treatment needs. On the other hand, other participants described how there are different issues between men and women to be addressed in treatment and described facing difficulties within a mixed gender treatment environment. The researchers concluded that there is a 'need to raise awareness of EDs in men; among professionals to facilitate detection, within society to decrease men's fears of a negative response and among men themselves to assist in the process of admitting that there is a problem' (p.10). As with de Beer's (2009) study, men with BED were not included in this sample without providing a rationale. As such, there is a notable gap in research exploring men's experiences of treatment for BED, which the current study aims to address.

Men and help seeking

Men might not seek treatment for their EDs for a number of reasons. The common misconception that EDs is a 'female phenomenon' has been found to prevent men from seeking treatment due to embarrassment and the stigma of being associated with a stereotypically considered 'girls' disease (de Beer & Wren, 2012; Weltzin et al., 2005). Another misconception in EDs is that men who do suffer from EDs are homosexual; therefore, men might not seek treatment due to inhibitions regarding their sexuality (Jones & Morgan, 2010). Furthermore, men are not considered to be a treatment-seeking population as they are less likely than women to seek help for EDs (Hay, Loukas & Philpott, 2008) or for a range of health issues (Pederson & Vogel, 2007; White, 2009).

Men who do seek treatment for their ED may be faced with poor recognition and detection of their ED from professionals. As discussed, men are less likely to be diagnosed with EDs simply because of their gender (Currin et al., 2007). Additionally, men who seek treatment are also faced with having no specialised treatment services and no specific treatment guidelines, as these have been developed based on women with EDs (Robinson et al., 2013).

Recommendations for working with men with EDs

Reviewing the clinical and empirical literature on men and EDs, de Beer and Wren (2012) recommend that practitioners focus on sexuality and gender issues, since the association of EDs with homosexuality and femininity may cause men to consider their masculinity flawed (Andersen & Holman, 1997; Drummond, 2002). Furthermore, de Beer and Wren (2012) suggested that specialised EDs services and treatment provision should be 'gender-sensitive'. Even though EDs are more common in women than in men, services 'should be mindful not to be explicitly female-focused' (p.432).This recommendation is supported by de Beer (2009) who explored men's experiences of EDs and found feelings of discomfort in men during treatment in relation to female-focused literature and self-help manuals. He recommends that clinicians who work with men with EDs be aware of such issues and that they make necessary changes, for example reprint material with gender-sensitive references.

Additionally, Strother et al. (2012) recommended that professional practitioners focus on specific issues pertinent to men with EDs such as body image, exercise abuse and media pressures as a way to improve intervention techniques and psychotherapeutic treatment modalities. They also recommend all-male therapeutic groups which might help men move away from the stereotypical belief that EDs are women's issues. Furthermore, Greenberg and Schoen (2008) suggested that mental health professionals need to consider the possible stigma men experience from suffering from an ED and to consider the impact of masculinity on assessment and treatment of EDs in men. They argue that men with BED need to feel more understood and less isolated in a society that stigmatises EDs as female disorders.

Counselling Psychology and applicability to professional practice

The current study focuses on men's subjective experiences and understanding of BED. These principles resonate with CoP as this discipline is mainly concerned with respecting and valuing subjective experiences and appreciating individual differences (Orlans & van Scoyoc, 2009; Woolfe, Dryden & Strawbridge, 2003). Within CoP there is an 'explicit appreciation of diversity

of experience' (Rafalin, 2010, p.45) and consistent with CoP values, the current research seeks to explore the diversity of experiences in men with BED since previous studies have only focused on women's experiences of BED.

In line with CoP values, this research seeks to inform professional practice and to contribute to 'a research base grounded in professional practice values' (BPS, 2005, p.1-2). There is empirical evidence suggesting that counselling psychologists and mental health professionals find providing treatment to individuals with EDs highly challenging (DeLucia-Waack, 1999), often leading to experiencing burnout (Warren, Schafer, Crowley & Olivardia, 2012). They have been found to experience changes in their perception of self and their relationship with food which further highlights the difficulty in working with individuals with EDs (Warren, Crowley, Olivardia & Schoen, 2009). Therefore, counselling psychologists and other allied health professionals are likely to be even more challenged in their work with men with EDs and BED due to the lack of clinical guidelines and limited research in this area informing professional practice.

Additionally, there is a lack of a substantial presence of EDs research articles in CoP journals (Hotelling, 2001). Petrie and Rogers (2001) argued that this fact 'may send the unfortunate message that eating disorders are neither important nor relevant to Counselling Psychology' (p.733). However, counselling psychologists are faced with clients with EDs in their practice which, as Buckroyd (2005) argues, as counselling psychologists 'we are often failing the clients who come to us with these (eating disorder) difficulties' (p.187). She further highlights the need for counselling psychologists to generate research findings from a CoP perspective to better inform CoP practice in EDs.

This research hopes to contribute to CoP and professional practice in the area of men with BED and to better inform counselling psychologists in their work with men with BED to enhance therapeutic efficacy. CoP research 'values a search for understanding' (Rafalin, 2010, p.41). Therefore, developing an understanding of men's subjective experiences of BED does not only reflect CoP's values but is also imperative for ethical practice (Olsen, 2010).

Research Rationale and Research Aims

There is an evident lack of research in exploring men's experiences of BED, as most studies investigating BED have only been conducted on women. Additionally, there is an evident lack of research focusing on men's experiences of treatment for BED. Professional guidelines and treatment protocols are only based on women, failing to emphasise men's needs, despite the growing gender differences literature in BED and EDs. As a result, counselling psychologists and other allied health professionals are likely to be highly challenged in their work with men with BED. Moreover, there is an evident lack of CoP research in EDs and BED in CoP journals.

This study aims to address these gaps by exploring men's experiences and understanding of BED. In doing so, it will attempt to provide men with BED with a voice to express their subjective experiences. This study also seeks to expand the CoP knowledge and research base in men and BED to better inform the professional practice of counselling psychologists and other allied health professionals working with men with BED. Exploring men's experiences of BED can be useful as any possible differences or similarities in their experiences of BED and treatment experiences, as compared to what is already known of women's experiences, would be informative for professional practice as it can affect the choice and approach of treatment by counselling psychologists.

Research Question

Following from this literature review and research rationale, this study will explore the following research questions:

1. How do men experience and understand BED?
2. How do men with BED experience and understand the process of seeking, accessing and receiving treatment(s).

Chapter 3

Methodology and Procedures

Methodology

Research design

A qualitative methodology was employed for this study using semi-structured interviews and Interpretative Phenomenological Analysis (IPA). The reasons for selecting this as the most suitable methodology for answering the study's research question (RQ) of how men experience and understand their BED are presented below.

Rationale for qualitative methodology

Using the RQ to guide the choice of methodology led me to select a qualitative methodology (Willig, 2001). Qualitative research aims 'to understand and represent the experiences and actions of people as they encounter, engage and live through situations' (Elliot, Fischer & Rennie, 1999, p.216). In contrast, quantitative research is concerned with identifying cause and effect relationships and in testing hypotheses by measuring variables (Willig, 2001). A qualitative methodology allows for an in-depth study of phenomena which are not easily quantifiable, as are men's experiences of BED. A further choice of methodology is required, as several qualitative approaches could possibly answer this study's RQ.

Interpretative Phenomenological Analysis

IPA is considered to be the most suitable methodology to address the study's RQ. IPA focuses on the detailed examination of lived experiences, the meaning these experiences hold for individuals and how the latter make sense of their lived experiences (Smith, 1996; 2008). IPA has three theoretical underpinnings in phenomenology, hermeneutics and idiography, which are outlined below.

Phenomenology is concerned with exploring individuals' subjective experiences. IPA is phenomenological as it 'is committed to the examination of how people make sense of their major life experiences' (Smith et al., 2009, p.1). As such, IPA is consistent with the RQ that aims to explore and understand how men with BED perceive and make sense of their experiences. Smith and Osborn (2008) argue that IPA is a dynamic process in which the researcher assumes an active role in trying to get an 'insider's perspective' on the participants' world (Smith, 2008). IPA recognises that individuals' experiences cannot be accessed directly; rather the researcher is required to engage with and interpret these experiences, which is IPA's hermeneutic underpinning (Smith et al., 2009). As the participants themselves are trying to make sense of their experiences, IPA engages in a double hermeneutic, where 'the researcher is trying to make sense of the participants trying to make sense of what is happening to them' (Smith & Osborn, 2008, p.53).

Another characteristic of IPA is idiography, which is concerned with the particular (Smith & Eatough, 2006). IPA is committed to the detailed examination of a single case and places value on individuals seen as distinct from one another before making more general claims across cases, which renders IPA as idiographic. IPA's inductive, exploratory and flexible features mean that it can be used to investigate under-researched areas of study (Smith et al., 2009); in this case, men and BED. Additionally, IPA has overlapping characteristics with the values of CoP. IPA is committed to exploring personal lived experiences, which corresponds with the philosophy of CoP that values each person's idiosyncratic experiences 'as valid in their own terms' and seeks 'to engage with subjectivity' (BPS, 2005).

Alternatives discounted

In order to make an informed methodological choice, different qualitative methods were initially considered but later excluded. Grounded theory (Glaser & Strauss, 1967) and IPA share an inductive approach to research (Smith et al., 2009). However, IPA is concerned with a detailed analysis of a small number of participants' lived experiences and engages with existing theoretical frameworks (Smith et al., 2009). In contrast, grounded theory is concerned with identifying

and integrating categories of meaning from a larger sample and seeks to generate theories to provide an explanatory framework to understand the phenomena under investigation (Willig, 2008). Additionally, individual accounts are drawn to support the theoretical claims generated from the data rather than interpretation of the data as in IPA (Henwood & Pidgeon, 2006). This study's RQ is specifically addressing men's experiences, rather than in generating theory. As such, grounded theory was not considered to be the most appropriate methodology to address the study's RQ.

Discourse analysis was another methodology taken into consideration which is concerned with language and its role in constructing social reality (Potter & Wetherell, 1987). IPA shares with discourse analysis the importance of language; however, IPA does not adhere to the assumption that language is the only tool necessary to construct reality (Smith & Eatough, 2006). IPA aims to obtain an insider's perspective on how people think and make sense of the phenomenon under study. In contrast, discourse analysis does not aim to produce knowledge of phenomena, but rather to produce 'an understanding of the process by which they are enacted in and through discourse and with what effects' (Willig, 2008, p. 108). As a result, IPA was considered to be the most suitable methodology for this research study.

Epistemological stance

My epistemological standpoint in relation to this research study draws upon a critical realist position (Bhaskar, 1978; Madill, Jordan & Shirley, 2000). Critical realism recognises that reality exists independently from our experiences and perceptions, while assuming knowledge not to be objective (Finlay, 2006; Lyons & Coyle, 2007). Critical realism asserts that 'the way we perceive facts, particularly in the social realm, depends partly upon our beliefs and expectations' (Bunge, 1993, p.231). Phenomena are therefore experienced and perceived in fluid and subjective ways, depending on individuals' idiosyncratic beliefs and expectations. Moreover, this standpoint seems in accord with CoP which is concerned with understanding and respecting people's subjective accounts and does 'not assume the automatic superiority of any one way of experiencing, feeling, valuing and knowing' (BPS, 2005, p.1-2). Additionally, IPA is

considered compatible with critical realist epistemology due to its meaning making focus (Reid, Flowers & Hammersley, 2005). IPA's hermeneutic feature is also in accord with a critical realist position which accepts the impossibility of gaining direct access to reality (Willig, 2008).

Procedures

Participants and Sampling

Purposive sampling was used as participants were systematically selected to fulfill the criteria of the study. Through purposive sampling, an IPA study aims to recruit a fairly homogenous sample for which the RQ is significant, therefore offering to the research insight into idiosyncratic experiences (Smith & Eatough, 2006). Generally, IPA studies have small sample sizes due to the idiographic nature of IPA (Smith et al., 2009). Based on Smith & Eatough's (2006) recommendations on sample size for IPA studies, six men were recruited.

Inclusion and exclusion criteria

Great emphasis was placed on recruiting a homogenous sample as advocated by IPA (Smith, 2008), whilst not restricting inclusion/exclusion criteria in order to maximise recruitment.

Male participants were selected due to the lack of research on men's experiences of BED. This focus ensures a homogeneous sample in relation to gender. Participants were required to be 18 years of age and above. Research findings show that individuals seeking treatment for BED are between the ages of 30 and 50 (Fairburn et al., 2000), whilst other research studies show that individuals suffering from BED are not limited to this age range (Decaluwe, Braet & Fairburn, 2002). In order not to replicate this bias by only looking at individuals between 30-50 years of age, a wider age range was included in this study to better understand individuals suffering from BED across age groups.

Participants were required to be fluent in spoken English. Due to the nature of the qualitative study, great emphasis is placed on the importance of language (Smith et al., 2009). There is a danger of jeopardising the richness and meaning of language if a translator is used, and, as a result, non-English-

speaking was set as an exclusion criterion. Participants were required to have received a formal diagnosis of BED from a health professional in order to facilitate homogeneity in the sample and ensure 'caseness' rather than relying on individuals' assumptions and self-diagnosis.

In keeping the sample as homogenous as possible, participants were required to be receiving treatment of any modality for BED for at least a year. This criterion was deemed necessary as a greater length of experience in treatment would ensure sufficient familiarity with the topic to address the RQ and also to facilitate consistency in the sample.

Participant demographics

The demographics for the six participants are described in order to situate the sample and enable assessment of the relevance of results (Elliott et al., 1999). The demographics are presented as a group instead of individually in order to ensure confidentiality and anonymity. Participants were recruited through EDs organisations, charities and social media. Due to the relatively small number of men with BED in these recruitment sites, the specific details of the sites will not be provided to protect participants' identities.

Six men between the ages of 22 and 50 were recruited and their first language was English. One participant identified himself as homosexual and five participants as heterosexual. Four participants were married or in a relationship, and two were single. Four participants were working full-time and two were self-employed. All six participants confirmed that they had a formal diagnosis of BED from a health care professional prior to the interview. Participants' struggles with BED varied in duration, between 2 to 20 years.

At the time of the interview, one participant was receiving CBT treatment and five participants were using self-help books. Four participants had received CBT and person-centered therapy treatment in the past. All participants used self-help treatment for the majority of the duration of their BED, varying between 1 and 10 years. The demographic information was collected verbally at the beginning and during the interviews.

Materials

The materials used in the research which can be found in the Appendices are:

- Recruitment poster
- Participant information sheet
- Consent form
- Interview schedule
- Debriefing form

Recruitment Process

Participants were recruited through different recruitment avenues. A recruitment poster (Appendix A) was emailed to various organisations that provide support to individuals with EDs across the UK for example Beat and Men Get Eating Disorders Too (MGEDT). Response to this recruitment strategy was slow and therefore other recruitment avenues were considered. To facilitate recruitment I created a facebook page dedicated to raising awareness in men and BED, and advertised the research by writing blogs providing details of the research, through Huffington Post, MGEDT and Student Run Self-Help organisations. I also advertised the research study through Men's Health magazine online forum, in gyms and in university student services. Other recruitment avenues that were pursued included contacting counselling psychologists and professionals working in EDs, for example through the BPS faculty of EDs and CoP social networks. The poster included the inclusion/exclusion participation criteria and the incentive of a £10 Amazon voucher.

Individuals were advised to contact the researcher by phone or e-mail to express their interest in the research. On the initial contact with the interested individuals, the researcher emailed details of the study including the participant information sheet (Appendix B). Individuals were asked to read the information sheet and contact the researcher if they had any questions and if they wished to take part in the study.

Through the recruitment process nine men contacted the researcher requesting further details about the study. A total of six men were recruited as these individuals fitted the research criteria. The interviews were conducted in

various locations, depending on participants' preferences, for example the participants' place of work and public areas.

Interview schedule

A semi-structured interview schedule consisting of open-ended questions (Smith & Osborn, 2008) was used as a guide for the interview (Appendix C). In line with the principles of IPA, the interview schedule was used flexibly which enabled a 'dual focus' where the interview was participant-led but also guided by the researcher (Smith & Eatough, 2006). The format of the semi-structured interview enabled participants to set the parameters of the discussion introducing novel areas where the researcher was able to probe for expansion. The interview schedule was developed through receiving feedback from the academic supervisor and IPA regional research group meetings. Following several drafts of the interview schedule, the questions were modified until a satisfactory stage was reached where it was felt the present schedule was adequately addressing the study's RQ.

Interview Process

At the beginning of each interview, the researcher discussed the information sheet and consent form in depth, allowing each participant to give fully informed consent. Participants were given the opportunity to ask questions before signing the consent form (Appendix D). Interviews lasted approximately 45 minutes to 2 hours and were recorded using a digital recorder, following the participants' consent. At the end of the interview the participants were fully debriefed and a distress protocol was in place for participants' safety and wellbeing (Appendix E and F). After each interview the researcher made notes in her reflective diary registering thoughts and observations concerning the interview process and captured non-verbal information to inform the analytic process (Smith et al., 2009). The interview process will be addressed in detail below in relation to ethical considerations.

Ethical issues

The research study was approved by the Research Ethics Committee at London Metropolitan University (Appendix G). In addition, full consideration was given to the ethical guidelines as proposed by the BPS Code of Ethics and Conduct (2009).

Prior to the interview, participants were informed that they could withdraw from the study without giving reason up until two weeks following the completion of the study. The researcher made clear to participants that they were under no obligation to take part in the study and their decision would not affect the treatment of care they were receiving. They were also informed of their right to refuse to answer any questions should they desire and they could pause or stop the interview at any point. It was made explicit to the participants that the purpose of the study was research and not therapy and any benefits were welcome but unintended.

During the interview, participants were asked to discuss personal experiences in some detail, which might cause them unforeseeable discomfort. Measures were taken to minimise this risk and to ensure that the participants' well-being was safeguarded during the interview; for example, non-verbal cues of distress were monitored and a distress protocol was put in place. At the end of the interview participants were fully debriefed and were given a debriefing information sheet. Participants were given the opportunity to ask any questions and discuss any feelings and concerns evoked during the interview. The researcher's and supervisor's contact details were made available and a list of contact details of organisations for further support was offered.

Participants were fully informed about confidentiality and its limits as outlined in the information sheet and also explained verbally. They were informed that all data would be kept strictly confidential at all times, personal identifying information would be altered and names anonymised using pseudonyms. Participants were assured that the consent forms and names of the participants would be kept separately from the data in a cabinet secured under lock and key. Participants were informed that the data was being collected as part of a doctoral thesis with the aim of eventual publication. It was emphasised that direct quotes would be used in the write-up with personal identifying information altered or removed, which participants gave consent to. They were assured that

data would be kept for five years in case of publication and then it would be erased according to the BPS Code of Ethics and Conduct (2009).

Validity

Yardley (2000) suggests four principles for assessing the quality and validity of qualitative research and these will be considered in terms of the present IPA study.

The first principle Yardley proposes is sensitivity to context. Choosing IPA as the methodology for this research study demonstrates sensitivity to context 'through close engagement with the ideographic and particular' (Smith et al., 2009, p.180). Through the difficult recruitment process the researcher displayed continuous engagement with the study and had to attempt numerous recruitment avenues. Interviews were conducted sensitively, respecting each individual and trying to facilitate rapport where participants felt comfortable and heard. This further reflects the subjectivity and intersubjectivity values of CoP (BPS, 2005). Similarly, sensitivity was displayed during write-up through carefully utilising verbatim extracts and through offering 'interpretations as possible readings grounded in the data and contextualising the report in relevant existing literature' (Shinebourne, 2011, p.27).

The second principle is commitment and rigour. Commitment was demonstrated by the researcher's attention to the participants during the interview process and personal dedication to the topic. In terms of rigour, participants were carefully selected to be a homogenous sample in order to adequately address the RQ. Also, great efforts were taken to sustain the quality of the interview, as numerous drafts of the interview schedule were produced. Additionally, conducting a thorough analysis demonstrates rigour, as the researcher attempted to engage with IPA data in an idiographic and interpretative, not only descriptive, manner (Smith et al., 2009).

The third principle is transparency and coherence. The researcher attempted transparency through a clear description of the recruitment process, of how the interviews were carried out, and through the analysis process, the use of quotes within the analysis section and the development of a transparency trail in the appendices. The present IPA study is consistent with the underlying

principles of IPA in that the phenomenological, hermeneutic and idiographic principles of IPA are present in the write-up. This study demonstrates coherence by 'attending closely to participants' experiential claims and at the same time, manifesting the interpretative activity of IPA' (Shinebourne, 2011, p.27).

The real test of validity lies with the readers-whether they find the research interesting and useful, thus evidencing the study's impact and importance, which is Yardley's fourth principle. This principle will be explored in detail in the discussion chapter under the research's applicability to professional practice (p.91).

Analytic process

The analytic process in IPA is iterative and inductive, where the researcher attempts initially to develop an 'insider's perspective' on the topic and subsequently to develop an interpretative account of making sense of participants' experiences (Larkin, Watts & Clifton, 2006). This study's analytic process was informed by Smith et al. (2009).

Analysis began after the completion of all interviews, thus implementing static sampling which enabled the researcher to bracket her assumptions and knowledge derived from each interview and focus on each participant's experiences (Willig, 2008). Additionally, each interview was analysed in-depth and individually which further permits bracketing of themes derived from each case and new themes to emerge with each case, keeping in line with IPA's idiographic commitment (Smith et al., 2009).

The recorded interviews were transcribed by the researcher before being subjected to analysis. The first stage in the analytic process involved repeated readings of the transcript and listening back to the recording allowing the researcher to become immersed in the data (Smith & Eatough, 2006). Transcripts were formatted with margins on the left and right-hand side for notes to be made, including line and page numbers. Initial impressions were noted on the left-hand side of the margin making exploratory annotations with descriptive, linguistic and conceptual comments, using different coloured pens.

The second stage involved re-reading the transcript and using the right-hand margin to note emergent themes developed from the initial notes and

drawing upon psychological concepts. This stage of developing emergent themes involves shifting between description and interpretation in an attempt to capture patterns and make connections between the exploratory notes (Appendix H).

The third stage involved drawing together these preliminary emergent themes according to links and similarities forming superordinate themes. Smith (2004) suggests researchers should imagine this process as 'a magnet with some of the themes pulling others in and helping to make sense of them' (p.71). A table was then produced consisting of superordinate themes together with their constituent themes and quotation references, allowing for each theme to be traced back to transcribed data (Appendix I).

Moving on to the next participant's interview, the same analytic process was followed until all cases were analysed and tables of superordinate themes were created for all transcripts. Across all six cases, 177 superordinate themes emerged. The next stage involved looking for patterns across cases, grouping together these 177 superordinate themes and in deciding upon which superordinate themes to focus on in the analysis. During this process, recurring superordinate themes were clustered together, some were relabeled and reconfigured and some superordinate themes were removed from the analysis. This was a challenging process as a number of factors influenced the selection of superordinate themes. For example, the most relevant themes to answer the RQ, as well as, the themes that highlighted novel and anticipated areas of men's experiences of BED were selected. The selection of superordinate themes was also influenced by the 'richness' and clarity of the verbatim extracts which helped to illustrate each theme (Smith & Osborn, 2008). Themes were also selected on the basis of prevalence, as well as, relevance in capturing 'unique idiosyncratic instances but also shared higher order qualities' (Smith et al., 2009, p. 101).

During this process a number of superordinate themes were excluded from the final analysis for example, 'the body as perceived and lived' and 'early life influence on relationship with food'. Even though these were very interesting themes, they were not particularly prevalent and were not particularly rich and clear in evidence within the transcripts (Smith & Osborn, 2008). A list of the excluded superordinate themes can be found in Appendix J.

Through this process 13 clusters of superordinate themes were created. These themes were then clustered under four master themes or broad organising categories of superordinate themes. The final table of themes was subsequently developed (Appendix K). The final stage of the analytic process was the transformation of the final table of themes into a narrative account outlined in the analysis chapter.

Methodological reflexivity

I will attempt to outline the potential impact I had as a researcher on this section of the research, further facilitating the study's rigour (Willig, 2008).One of my initial presuppositions was that men with BED experience stigma for having a 'female disorder'. I realised how the existing EDs literature and my beliefs on gender-specific behaviours led me to hold this presupposition. As Kasket (2012) suggests, a counselling psychologist needs to remain open to different perspectives in order to explore them throughout the research. As such, men with BED might not experience stigma or it might not be of such importance to them. Another presupposition I had was that men find it difficult to express their thoughts and feelings. My assumption of gender-specific behaviours led me to blindly assume that men would not express in detail their experiences of BED.

Through reflexivity I realised that I was imposing these presuppositions on the initial drafts of the interview schedule. My initial interview questions were structured and leading in an attempt to ensure that men would express themselves and focus on stigma. Reviewing the interview schedule in supervision and in the IPA regional research group, I was able to identify and monitor my presuppositions in order to avoid 'blocking out the participant's voice' (Finlay, 2002a). Therefore, the interview schedule was constructed to prioritise participants' experiences and not to be based on the researcher's presuppositions. I also failed to consider an important ethical issue while constructing the interview schedule. I used the diagnostic term BED throughout the interview questions without considering that the participants might not identify themselves with such a diagnosis, or dislike labelling their eating issues as such. During the

interview process, I monitored this issue by adhering to each participant's line of reference and used the term they felt more comfortable using when referring to BED.

Recruitment was a difficult process in my research journey, lasting for 14 months. Approaching the recruitment process in a systematic and rigorous manner, I used multiple recruitment avenues as described above. As Morrow (2005) suggests, another reflective practice is to consult researchers and one fellow CoP researcher advised me to patiently build trust within the EDs community in order to recruit participants. Following this advice, I tried to build trust in the community by writing blogs on men and BED and advertising the study. I also looked at the literature on hard-to-reach population research and sensitive research (Abrams, 2010; Liamputtong, 2007) to inform myself of other possible recruitment avenues. Managing and tolerating uncertainty in the recruitment stage was important as it involved perseverance in finding new recruitment avenues which further enriched the 'process of becoming a reflexive researcher' (Etherington, 2004, p. 81).

Reflexivity led me to new insights during the interview process. Before each interview I would read my reflexive journal in order to enhance my ability to 'bracket' my presuppositions. I have attempted to conduct each interview as a naïve researcher respecting each participant's unique experiences, thus upholding my profession's values (Orlans & van Scoyoc, 2009). At the end of the interview participants expressed their gratitude towards the researcher, and for the opportunity to participate in the research. Some participants commented that they felt more motivated to engage in their treatment for BED and described how expressing themselves in the interview gave them a greater sense of understanding their struggles with BED. Demonstrating CoP values through the interview process, it can be argued that participants experienced the interview process 'as empowering and facilitative of understanding and growth' with regards to their BED (Kasket, 2012, p.68).

Chapter 4

Analysis

Overview

This chapter will present the results of an IPA of six men's experiences and understanding of BED. Four master themes emerged from the analysis consisting of 13 superordinate themes across all cases:

- The experience of BED
- The process of understanding
- The stigmatised male self
- The experience of treatment

Each master theme and superordinate theme will be described followed by the researcher's interpretations of the participants' accounts, thus adhering to IPA's double hermeneutic. Verbatim extracts will be used to firmly ground the interpretations made in the data. It is acknowledged that these interpretations offer one possible conceptualisation of participants' experiences of which other researchers may offer a different understanding.

In order to improve readability throughout the verbatim extracts minor changes were made; omitted material is indicated by dotted lines within brackets (…) and repeated words or utterances were removed. All identifying information was removed and pseudonyms were used to ensure participants' anonymity. The master themes and super-ordinate themes are presented in Table 1 below. Additionally, the main master table of themes across cases can be found in Appendix K.

Table 1

Master and Superordinate Themes

Master themes	Super-ordinate themes
The experience of BED	The dual facet of BED The futile struggle for self-control 'Binge frenzy': the experience of dissociative craziness Living with BED
The process of understanding	Turbulent quest: in search of an understanding Food addiction Functionality of BED
The stigmatised male self	Male stereotype: Being a 'macho male man' The stigma of BED Sense of self
The experience of treatment	Seeking and accessing treatment: Struggling alone in search of unavailable support Challenges in receiving treatment Treatment focusing on men

The experience of BED

This theme encapsulates men's experiences of BED. Participants describe divergent experiences of negative and positive facets, characterised by a strong sense of loss of control during binge eating episodes. Additionally, they reflect on the experience of living with BED.

The dual facet of BED

This theme addresses the divergence of men's experiences as they describe positive and negative facets of their BED. Participants describe the initiation and duration of the binge episode as an enjoyable experience which is then transformed into a negative experience as they experience shame, regret and guilt. Chris describes enjoying his binge eating as he associates food with nurturing, love and familial meals. However, at the end of the binge eating, instead of the positive feelings he expects to attain, he is shockingly faced with negative feelings:

> 'you kind of get a big shock from it (…) because you expect to have all of these wonderful, warm, kind, fuzzy, nice support of family type emotions associated with it but then it's the realisation of the amount of the food that you've eaten (…) it then brings a demented…that's like a tonne of bricks' (Chri:34/7-14)

Chris is shocked when he realises the quantity of food he ate which can be understood as 'a tonne of' food. The extent of his shock may be similar to being hit by 'a tonne of bricks' which appears to be painful and harsh. This is in sharp contrast to the initial positive feelings Chris associates with binge eating. As such, the experience of binge eating appears to be overwhelming as if going crazy or 'demented'; a pervasive theme throughout participants' accounts. Possibly experiencing both the negative and positive facets of binge eating may create an immense sense of confusion; that is similar to being 'demented' or experiencing an emotional and mental deterioration. Chris further describes having a difficult relationship with his family where he never experienced a 'close and emotional bond'. Possibly binge eating serves a psychological function for Chris in providing him with comfort and love. This can be interpreted as Chris having underlying unmet needs which he seeks to fulfill through food and binge eating. Similarly, Peter describes the dual consequences of binge eating:

> 'it's going to be the best party I ever had in my life (….) you don't want it to end because you can't put any more food inside of you because it's over and then you are faced with reality' (Peter:11/15-12/11)

Peter associates binge eating with a party where he can enjoy food he desires. He describes prolonging his binge eating to avoid facing reality at the end of the episode. This may be interpreted as experiencing a desirable sense of dissociation from reality during his binge eating. However, when the binge 'party' ends, he experiences the negative consequences as:

> 'a bullet ball in your stomach' (Peter:12/30)

Through this metaphor Peter describes the actual physical pain experienced at the end of the binge episode where large quantities of food are consumed as having 'a bullet ball in your stomach'. This can also be understood as either being shot in the stomach which reflects the extent of the physical pain or as being suddenly shot back into painful reality. Perhaps it also conveys the sense of having done something destructive or harmful to one's self and body. Similarly, Danny describes:

> 'after the binge I am in so much pain, all I can focus on is how disgusted I feel (…) and how I am going to add to my stretch marks' (Danny:12/12-17)

At a deeper level of interpretation Danny possibly experiences his binge eating as a form of self-harm. He internalises the harmful consequences of his actions as causing self-inflicted physical pain. His use of 'I' suggests that he views himself as the agent of this action, rather than blaming his BED. Danny appears to experience remorse and embarrassment for his binge eating which is further compounded by his inability to hide his BED as its consequences are physically evident in his weight gain and stretch marks.

Participants also talked about their experience of receiving a diagnosis of BED and described divergent accounts of positive and negative experiences. In Danny's account:

> 'having an eating disorder [is] like having any kind of failing or flaw or something that was not functionally right' (Danny:17/9-10)

On receiving a BED diagnosis Danny feels there is something inherently wrong with him and views himself as a failure or as being flawed. Throughout his account Danny describes having a strong work ethic. He possibly experiences BED diagnosis as an imposed weakness or stamp which damages him and impedes him from functioning and therefore performing in his work. This might convey a sense of deficiency in being impaired or broken down even by his BED.

Chris describes his initial reaction to receiving a BED diagnosis as a relief, as it provides him with an explanation for his enduring weight struggles. He has hopes that the diagnosis means he will receive treatment for his BED. Chris then expresses a differing view of his diagnosis:

> '[to] not have information to hand about the specifics of binge eating disorder, it became kind of, well is it just something that they've got a term (…) you've got a name for it, but the fact that they really haven't figured what it is (…) does kind of knock that confidence' (Chris:20/25-35)

Chris describes losing his initial confidence in the diagnosis due to the lack of information and treatment available for BED. By referring to the diagnosis as 'a name' and 'a term' Chris attempts to minimise the importance of the diagnosis reducing it to an insignificant label. Chris makes clear distinctions between 'I' and 'they'. Possibly 'they' refers to mental health professionals with whom he appears disappointed. Distinctions between 'I' and 'they' possibly highlight the isolation experienced by men who believe no one can understand or treat their BED.

These negative accounts were juxtaposed with positive ones. This is illustrated in Peter's account:

> 'for me it was a puzzle that I could suddenly be solved' (Peter:2/13-14)

Peter describes his struggles with BED as a puzzle which was solved by receiving a diagnosis and offered immediate clarity and understanding to his situation. Possibly Peter experienced an intense confusion while trying to make sense of what is happening to him. It is similar to a puzzle with missing pieces or

to being puzzled by BED. The use of 'I' suggests that BED is an internal and not an external struggle. This can be further interpreted as an internalisation of BED being an internal part of Peter's self.

The futile struggle for self-control

The theme of self-control appears in all men's accounts. The loss of control appears to be a futile struggle as men continuously struggle to control their binge eating. Sam describes an internal futile struggle to control his self from binge eating:

> 'you are denying yourself the food, or certain foods, so that would just build up over time and eventually you just can't hold it anymore (…) you have this urge that is built up inside of you, you got it and just increased (Sam:2/32-3/2)

Through his account Sam describes various triggers such as loneliness and low mood leading to binge eating. Possibly through binge eating Sam tries to fulfil his need to feel comfort, relief and happiness. He appears to be aware of this intense need inside himself which he denies and fights against it. This then gives rise to anxiety, both in terms of not wanting to give in to this need and also not wanting to gain weight. However, the need for gratification and possible lack of any other resources to meet this need means it is impossible for Sam to resist the impulse to take what he feels he needs. As a result, binge eating occurs which Sam feels ashamed of, possibly due to his perceived inability to control himself over food and the destructive effects that follow; he is also ashamed of his neediness and perceived greed over food. Possibly through bingeing Sam experiences loss of control as dis-inhibition in letting himself go into satisfying his needs. It can also be suggested that the urge to binge eat appears to be an internal struggle as it is 'inside of you' rather than being an external force, as if BED is internalised as an extension of Sam's self. Similarly, Tom describes:

> 'I would pour myself out (…) that little turns into a bit more, a bit more' (Tom:5/5-7)

Tom is possibly restraining himself from fulfilling his needs through binge eating. He almost tortures himself in not giving into his needs by allowing himself to eat small amounts of food. Eventually he cannot contain himself or the desire to fulfill his needs and he ends up binge eating. This suggests an intense and complete loss of self-control. It seems that by pouring himself out, Tom expresses his needs without any restraints. By physically filling up his stomach with food, his emotional needs are then fulfilled. Chris further describes experiencing a complete loss of self-control:

> 'this instinct that takes over, that compels me to do it (…) being compelled to eat the bad things' (Chris:5/16-27)

BED is personified as something powerful and 'bad' which compels Chris to binge eat. Possibly 'bad' refers to food he avoids or restricts in order not to gain weight. Similarly, Peter refers to his binge eating episodes as 'sins' which suggests binge eating is perceived as gluttony, one of the seven deadly sins. There appears to be something darkly compelling, an almost sinister quality in binge eating, which these men feel overpowered by and therefore compelled to binge eat. These men appear to be attributing their binge eating to this external and powerful compulsion which provides them with the means to deny any personal responsibility for their binge eating.

'Binge frenzy': the experience of dissociative craziness

In addition to men's experiences of losing self-control over eating, participants describe experiencing their binge eating as 'binge frenzy'. The binge episode appears to be an intense period of temporary craziness as they describe losing themselves when binge eating. Participants also express a strong sense of dissociation during the binge episode which they describe as 'an out of body experience':

> 'it quickly became I suppose a frenzy, it was kind of just blurred out from myself (…) mentally you take into account of what you were doing, it

> would then become something so manic that the food be placed without any thoughts or caring about what you are eating' (Chris:8/22-28)

Chris describes binge eating as a 'frenzy' which can be understood as an intense, uncontrollable experience of craziness, further reinforced by his use of the word 'manic'. He appears to dissociate during the binge eating from his thoughts and concerns, including his concerns about the binge eating. The experience of dissociation is further reinforced by Chris:

> 'binge frenzy (...) this complete and utter lack of emotions through the binge episode, you feel like this, kind of, an out of body experience (...) imagine being in a totally silent movie, so then a click of a switch being this oh an epiphany or a sound, it's that kind of rush of emotions in your head and its always you know negative emotions' (Chris:15/3-15)

Through watching himself act in a 'silent movie' Chris appears to be suggesting that he is observing himself binge eat. This is similar to 'an out of body experience' which can be interpreted as observing one's self from above. This strong sense of dissociation further reinforces the loss of control of self and agency over eating. Possibly binge eating is an actual 'silent movie', where in a silent movie there is no colour or sound only movements; in a binge episode there are no emotions or thoughts only food being placed in the mouth. The end of the binge is experienced as a sudden realisation of what has just happened which results in a flooding in of negative emotions of regret, guilt and shame. The word 'always' emphasises the inevitability to control binge eating and the constant negative consequences of binge eating.

Jack also experiences his binge eating as an 'out of body experience'. This is understood as Jack experiencing a complete loss of self-control over eating, which is experienced as dissociating from self:

> 'a feeling of dissociation or feeling of not being in control of, an almost like out of body experience' (Jack:4/18-19)

Peter also describes himself as 'insane' during binge eating episodes:

> ‘going off, you know, these mighty binges all night long (…) makes you feel very insane, very weak’ (Peter:7/27-30)

Peter appears to be experiencing binge eating as a crazy episode of ‘mighty binges’ where he consumes large quantities of food lasting ‘all night long’. It can be suggested that losing control over self and eating is experienced as losing one’s sanity. This is further experienced as a weakness as he is not able to control or stop this ‘insane’ behaviour.

Living with BED

This theme encapsulates the experiences of men living a constrained life due to BED, which they find to be shameful and isolating. Men also describe being trapped in a vicious cycle from which they constantly struggle to escape. Danny shares the following sentiment:

> ‘there is still something really shameful about binge eating; (…) because that’s like admitting that’s all there is: you massively overeat food; you lose all control around food. I think that compounds the isolation (…) you feel as if you’re an oddity, as if you are completely alone’ (Danny:31/12-21)

Danny reveals a sense of shame linked to his BED as he perceives it to represent a character flaw, possibly of being greedy and lacking willpower. Being ‘completely alone’ highlights his experience of living in isolation with a shameful condition, reinforced by not knowing another man with BED. He appears to be viewing himself as an outcast, or even as ostracised, due to having BED, which further ‘compounds the isolation’ he experiences. The word ‘compounds’ may refer to Danny’s sense of confusion as he experiences mixed positive and negative feelings for this BED. It appears that on one hand Danny wants to recover from BED and on the other hand he does not want to let go of the perceived benefits and functions of his binge eating. This in turn creates feelings of ambivalence in recovering from BED which can explain Danny’s feelings of being trapped in his BED. Similarly, Jack describes:

> ‘It’s going to be with me for the rest of my life and it’s not something that I can ever say I don’t have this (…); it’s been the same circle for all of my life since I was 16. Same story over and over and over again.’ (Jack:18/1-29)

Jack reveals how BED has become a part of his life which he feels he will never be able to completely recover from. His despair in living with BED is evident through the extensive repetition of ‘over and over’. There appears to be a debilitating sense or perhaps a doomed inevitability in Jack’s experience of living with BED, suggesting feeling trapped in an inescapable cycle; a theme strongly present in all men’s accounts. Perhaps BED has become part of Jack’s identity and this indicates a level of ambivalence towards the BED, for example experiencing positive feelings such as BED being a source of comfort, as well as experiencing negative feelings of guilt and shame, similar to Danny. Possibly this underpins the sense of confusion some of the participants experience and may serve as an explanation as to why it can be so difficult for these men to change their binge eating behaviours and recover from BED.

Participants further describe their experiences of living with BED in relation to their recovery, which is depicted as a constant struggle. This is illustrated in Peter’s account:

> ‘I always feel like recovering (…) I have been in that dark, dark world’ (Peter:24/6-9)

Peter describes his experience of living with BED as ‘dark, dark world’. This can be interpreted as a scary, almost sinister experience reinforced through the repetition of ‘dark’. Shifting between present and past tense may represent the repetitive movement of the BED cycle. Peter’s use of ‘recovering’ rather than ‘recovered’ represents his ongoing efforts in recovering from BED.

The process of understanding

Understanding BED was described as a difficult process for all participants as they go through a turbulent quest in their attempt to make sense of their BED. These men express their understanding of BED as having a function that is similar to an addiction.

Turbulent quest: in search of an understanding

This theme addresses men's struggles in trying to understand what BED is and why they engage in binge eating. Men appear to be searching for this understanding which is a turbulent quest, rendering them in an internal dialogue of questioning themselves and their emerging understanding. Men express differing views of their understandings but share feelings of confusion and uncertainty as they struggle to make sense of their BED. This is illustrated in Tom's account:

> 'Why am I doing this? I didn't know so to understand that this is what it is, this is why you are doing it (….) this might not be correct, this may be what might be happening (….) when there are no excuses then I suppose I got start asking questions' (Tom:3/31-4/15)

Tom appears to be experiencing an overwhelming sense of confusion as he constantly shifts between understanding and not understanding his BED. He even questions whether his emerging understanding is correct. Tom is no longer able to justify his binge eating and now he has to face the reality of his BED. Perhaps Tom is not only questioning himself but there is also a sense that he is questioning the researcher (and mental health professionals in general) in order to find the answers he is looking for. This suggests a great sense of despair, almost being tormented by his BED. Finding, therefore, any sort of understanding may provide him with relief. Questioning his own self in search of an understanding is also evident in Jack's account:

> ‘I don’t know if that’s just because I would be nervous of going to sleep or wasn’t an issue of falling asleep, it was just that, I don’t know bad dreams?’ (Jack:6/18-22)

Jack appears to be experiencing great difficulty in making sense of his binge eating. He engages in an internal dialogue, shifting between questioning himself to providing answers he is not sure are correct, as Tom had done. Jack’s understanding of his BED may be interpreted as oversimplified and shallow as he attributes his binge eating to having sleeping problems. This enables Jack to deny the severity and extent of his binge eating problem and perhaps illustrates resistance towards accepting his BED.

Similarly, Peter expresses his struggles in trying to understand his binge eating and engages in an internal dialogue:

> ‘part of it is doing it and part of it is trying to make yourself feel better about the fact that when this is over its going to be horrible so how do you make yourself feel better for a horrible experience?’ (Peter:11/4-7)

Peter divides his emerging understanding into two parts. One part of binge eating he understands as the actual act of eating. An alternative understanding for binge eating is that it serves a function; to make himself feel better. Peter appears to be binge eating in order to avoid the episode coming to an end which is a ‘horrible experience’. A possible interpretation is that binge eating serves as a dissociation from the negative consequences of the binge eating itself. Peter questions his understanding which, similar to Jack and Tom, suggests experiencing confusion as he struggles to make sense of BED, which is further evident through the juxtaposition of different emotions, ‘better’ and ‘horrible’.

In contrast, Chris describes BED to be an ‘evolutionary thing’ as the societal roles of men have changed. Through evolution men don’t need to hunt and as food is more readily available in supermarkets, a different lifestyle has been created. Chris appears to understand BED as occurring due to the abundance of food available, making binge eating feasible:

> ‘it’s kind of an evolutionary thing (…) ancestors, who have very clearly defined roles in the community and the social groups, would go out hunt (…) if this lifestyle hadn’t come about, then there wouldn’t be an opportunity to have that binge episode because there wouldn’t be availability of food’ (Chris:32/20-33/2)

Chris ‘evolutionary’ understanding of his binge eating may be interpreted as a weak explanation as he appears to be attributing his binge eating to external factors such as society and abundance of food. This provides him with the means to deny any personal responsibility or even ownership of his binge eating. Possibly through evolution men have comprised their masculinity as they no longer hunt their meals but can shop them in a supermarket. Perhaps Chris is describing a flawed sense of masculinity which through binge eating, and therefore consuming large quantities of food, he is able to regain and feel more masculine.

Food addiction

All men but one, describe understanding their BED as an addiction to food. These men appear to compare BED to addiction as a way to relate what they are going through to something they can more easily understand. Danny illustrates his understanding of BED as compared to addiction:

> ‘if you are addicted to alcohol or drugs or even painkillers, then you can go cold turkey with those, you can stop taking them (…) but when your addiction is food itself, you have to keep eating’ (Danny:5/20-25)

Danny understands BED as being addicted to food similar to being addicted to alcohol, drugs or painkillers. He views treatment for BED to be more difficult than treatment for addictions as he cannot completely abstain from food, whereas people can abstain from using drugs. Danny also appears to be conveying a debilitating sense in never being able to recover from BED as there is no escaping from food, as food is needed in order to survive. Possibly food is perceived as a vital necessity and at the same time as a harmful drug. This further

reflects the sense of confusion and ambivalence towards recovering from BED which some of the participants appear to be experiencing.

Similarly, Sam expresses his understanding of binge eating as compared to addictions. He compares the urge to binge as being similar to, and even stronger than, the urge to smoke. It appears that it is difficult for Sam to describe his understanding of binge eating and he compares it to smoking, which he can relate to more easily:

> 'It's difficult to describe it, probably almost like an addiction, like smoking (…) that sort of craving but it's a lot stronger' (Sam:1/26-30)

In addition to understanding binge eating as an 'evolutionary thing', Chris describes understanding his BED as a 'food addiction'. He speaks about having 'an emotional tie with food' which he understands as being addicted to the positive feelings he associates with food and family meals:

> 'that emotional tie is then something that you crave (…) I haven't had that, I need to have that, and then that becomes the addiction' (Chris:33/17-26)

Chris appears to associate his 'food addiction' as being addicted to attaining feelings of love and happiness. Chris craves these positive feelings he has not experienced with his own family and attempts to attain them through binge eating.

Functionality of BED

The theme of functionality of BED emerged from more than half the participants' accounts. Binge eating for these men helps them to dissociate from their own selves, thoughts and feelings but also to regulate their emotions. They also appear to understand their BED as having a protective function, helping them to cope and 'escape' from the difficult issues in their lives. The functionality of BED is strongly illustrated in Danny's account:

> ‘the binge serves as a vacuum, for me, so in that vacuum nothing is happening, I am no one, I don’t feel or look a certain way, it’s like literally I cease to exist’ (Danny:18/4-7)

Danny is describing the function of binge eating as being a ‘vacuum’. During binge eating it appears that Danny is experiencing a strong sense of dissociation from his self, thoughts and feelings. He experiences this dissociation as ‘a vacuum’ where there is nothing present and he does not exist. Additionally, a vacuum can be interpreted as a dark force which pulls everything in, similar to the compelling urge which pulls these men in and they cannot stop themselves from binge eating. Possibly, Danny is describing a strong self-aversion as he appears to be unhappy with and not accepting his self and appearance. This suggests a low self-esteem and self-worth further compounded by feelings of guilt and shame after the binge. However, binge eating enables Danny, even temporarily, to dissociate from his own self. Danny further illustrates another function of BED:

> ‘it’s two-fold, it is trying to be protective because it gives me space where nothing exists and I don’t have to think about stuff that is troubling me, including the binge eating (…) the binge eating disorder becomes a way to escape from the fact that you are unhappy about the results of the binge eating’ (Danny:30/14-37)

Danny describes how BED functions as a ‘protective’ mechanism, helping him to cope with the difficult and negative issues in his life which he possibly finds overwhelming and difficult to manage. This can be interpreted as BED having two functions; affect regulation and dissociation. Perhaps BED functions as an ‘escape’ from negative thoughts and feelings and from the negative consequences of the binge eating itself such as weight and stretch marks.

Peter echoes Danny’s understanding of the functionality of BED as self-protecting as he describes binge eating as ‘a tool, a weapon’. Binge eating appears to be Peter’s ‘weapon’ in protecting himself from negative feelings such as fear and anxiety which he experienced during his childhood and later on in coping with strenuous full-time studying and working. It can be suggested that

BED enables Peter to dissociate and therefore cope with the negative experiences of trauma he most probably experienced in his childhood by having a physically violent father. Binge eating can therefore be understood as having an affect regulation function as it makes Peter, however temporarily, 'feel better':

> 'food is a tool, a weapon in my tool bag to help me feel better; it can make me feel better even though it's only temporarily' (Peter:17/24-26)

Jack further expresses:

> 'I would say it's down to that needing to escape, use food as an escape to control [feeling] anxious' (Jack:1/30-32)

Jack describes not wanting to deal with negative feelings and uses food as a way to manage these feelings. Binge eating then appears to serve a function of 'escape' and therefore coping with anxiety. An interesting oxymoron interpretation can be made here. Jack possibly feels relieved for expressing his needs and finding a way to meet these needs through binge eating, even though he feels ashamed and guilty afterwards. It appears that through binge eating he (re)gains a sense of managing or coping with his feelings, but also seems to be about losing control and then feeling better. This oxymoron may explain why men feel so confused over their experience of binge eating.

The stigmatised male self

This theme encapsulates men's sense of self in relation to experiencing the stigma of having BED. The theme of male stereotypes is described to illustrate men's perceptions of what they perceive a 'macho male' man to be. This theme serves as an introduction to the next theme as men experience the stigma of having BED as they perceive themselves not fitting in with the male stereotypes.

Male stereotype: Being a 'macho male' man

The theme of male stereotypes is strongly portrayed throughout all men's accounts. They describe what the male stereotypes are in relation to physical appearance, physical exercise, behaviours and food. Men adhere to these stereotypes in order to fit in with other men and be perceived as 'macho male' men. The men describe an ideal male physique that combines thinness and muscularity, which they associate with a masculine stereotype of being a man. This is illustrated in Danny's account:

> 'the current ideal is to be manly but that manliness is in the form of a kind of an exaggerated masculinity (…) we are wanting a body ideal for men with that kind of rippling muscles and big' (Danny:19/13-21)

Danny views the ideal male physique as a physically strong body with big rippling muscles. This portrays the image of a perfect, powerful, invincible male body. This can be interpreted as an invincible armor made of steel which protects one's self against others. Possibly Danny idealises such a muscular and masculine physique in order to protect himself against being viewed as weak and fragile for having BED. Similarly Sam describes:

> 'I just wanna kind of fit in, to mesh but not to stand out (…) all of my friends are very slim (…) I would prefer a muscular six pack but that's not ever going to happen' (Sam:10/5-11/6)

Sam expresses the importance of attaining an ideal physique of thinness and muscularity in order to 'fit in' with other men. It appears that these ideals are unattainable for Sam which suggests the difficulty of adhering to male stereotypes. Throughout his account, Sam emphasises the importance of participating in sports as a way of fitting in the male stereotype which is reinforced by his desire to join the royal marines. Peter also expresses his desire to join the royal marines. It can be suggested that royal marines embody the stereotype of a strong 'macho male' man. Assuming a stereotypical masculine identity by being a royal marine may be interpreted as an attempt by these men to defend against being stigmatised as feminine or weak for having BED. The

theme title ‘macho male’ was taken from Peter’s description of how he perceives the stereotype of being a man as not having BED, which is illustrated in the next theme. Additionally, Chris illustrates the male stereotype of being a ‘macho’ man:

> ‘the macho kind of image (…) being the guy that goes down the pub and drinks 12 [pints] easily, has curry at the finish and then having a laugh with the lads (…) guys do that to save face because I mean, I don’t particularly enjoy that sort of thing (…) men try to fit into that whole macho kind of stereotype just to fit in with everybody else’ (Chris:18/1-10)

Chris portrays what he considers to be stereotypical male behaviour of ‘lads’ drinking and eating excessively. As Chris was part of a sports team, he used to engage in such outings, which he did not enjoy. Chris appears to succumb to social pressures to fit into male stereotypes, in order to fit in with other men.

The stigma of BED

All of the men describe experiencing stigma for suffering from BED as they perceive EDs to be associated with women and/or homosexual men and therefore not fitting in with the male stereotype. They further describe experiencing stigmatisation of character for having BED. Interestingly, some men express how the male eating behaviour stereotypes enable them to hide their BED. Tom and Peter describe BED, and associated behaviours, as being ‘a female or gay thing’:

> ‘For me it’s a girl thing or a female thing to check yourself in the mirror, to be obsessed with diets (…) it’s either a girl or sort of a gay thing’ (Tom:8/32-9/2)

> ‘They are gay and a weak person. Might think that they are making stuff up, that’s how I would perceive it’ (Peter:6/1-8)

Both participants appear to perceive men with BED, including themselves, as being weak and not manly for not being able to solve their ED and therefore not fitting in with the male stereotype. Peter further describes how since men are not associated with EDs, those who claim to have an ED are considered liars.

Danny believes BED stigmatises a man as 'greedy' and as lacking willpower. He rejects this, perceiving himself as possessing strong willpower:

> 'It's too easy to dismiss it as somebody is greedy or somebody needs to have more willpower, because I have a willpower of steel' (Danny:17/26-28)

It appears important for Danny not to be perceived by others as weak or greedy. Perhaps this is truly how he perceives himself to be and he fights against it. Danny's inability to use his strong willpower to stop bingeing further reinforces his fear of being stigmatised as weak. This can also be understood as despite his strong willpower Danny does not stop bingeing as a part of him does not want to give binge eating up. Possibly this part of himself is the part that recognises the functionality of binge eating in his life which he holds on to. This further suggests the internal struggle these men experience in wanting to recover from BED but at the same time not giving binge eating up.

Despite the fact that participants experience having BED as not fitting in with the male stereotype, some participants describe how binge eating actually fits in with the stereotypes of male eating behaviour, which enables them to hide their BED:

> 'you are kind of overeating quite regularly [and] because you are a guy they'll just say: oh well he's got a big appetite' (Chris:17/1-3)

Possibly Chris is suggesting that overeating and binge eating are considered socially acceptable male behaviours. The fact that it is acceptable for men to overeat enables men to conceal their BED from other people. Possibly male stereotypes make it more difficult for men to recognise their binge eating as problematic and to admit to having BED. Similarly, Jack describes:

> ‘it’s much easier to be a binge eater and a man, than it is to be a binge eater and a woman (…) I can eat a whole back of ribs or steak, that’s a good thing it means I am a man’ (Jack:12/17-30)

Jack describes how binge eating is a more acceptable behaviour in men than women as eating large quantities of food reinforces manliness. It appears that Jack considers himself to be fitting in this way with the stereotype of a ‘macho male’ man. Tom echoes Jack’s account:

> ‘I prefer to be a man with this difficulty than a woman because I think a female who binges isn’t particularly attractive (…) whereas as a bloke, it’s not acceptable to have an eating disorder but it is acceptable to eat a lot’ (Tom:7/31-8/1)

Tom expresses how it is more acceptable for men than women to have BED which can be understood as trying to diminish the impact and therefore stigma of BED in his life and normalise BED in men. Tom further highlights a dual facet of BED, as on one hand it is considered acceptable for men to overeat but it is not acceptable to have BED. Having contrasting stereotypes that these men feel they need to adhere to in order to be ‘macho male’ men may contribute to the feelings of confusion and ambivalence some of the participants experience and suggests the difficult struggle these men go through in understanding and accepting their BED.

Sense of self

BED appears to transform participants’ sense of self into a negative perception of a weak self. This is illustrated in Peter’s account:

> ‘as a guy I was always trying to look through at myself and say you are weak, you are specifically flawed’ (Peter:1/24-26)

A possible interpretation is that Peter experiences a fragile sense of self, characterised by low self-worth. He possibly perceives himself as being less of a

man, unable to fit into the 'macho male' stereotype. Being 'specifically flawed' may be understood as experiencing his BED as rare, therefore perceiving himself as an outcast for having a disorder rarely associated with men. Tom shares this sentiment:

> 'the stigma of the people thinking that you might not be able to do something or you are not good enough or I suppose they'd lock you in a lie (…) you want to be seen as being stronger than that' (Tom:3/15-19)

Tom experiences the stigma of BED as being perceived as incompetent and 'not good enough'. He describes this stigma as being locked in a lie and in being perceived to be someone he is not. Being locked in also reflects men's experiences in living with BED as they feel trapped and unable to escape from their BED. He perceives himself to be stronger than what BED makes him. Sam's perception of self is also affected by his BED:

> 'you wanna be the male, the strong (…) you get scared of eating, you get scared of food, you get scared of everything' (Sam:12/10-14)

Sam desires to be a stronger man which BED does not allow him to be as he is consumed by fear, rendering himself to have a fragile and vulnerable sense of self. Interestingly throughout these men's accounts there is a juxtaposition of weak and strong. They perceive themselves as strong men but they feel BED makes them weak, flawed and fragile. Perhaps BED reflects a pre-established fragile sense of self these men hold for themselves; that is their weak sense of self exists underneath BED. Therefore, having BED further exacerbates this sense of self into viewing themselves even more negatively.

Furthermore, some participants describe different views as to whether they perceive BED to be part of their selves, a theme present throughout their accounts. Jack does not internalise his BED as he perceives BED as separate from his self. It can be suggested that by perceiving BED as a separate and external force, then he is more able to fight against it and actually overcome his struggles with BED. This may also suggest Jack's ambivalence towards accepting BED:

> ‘it’s not ingrained in me you know, it’s not part of my DNA’ (Jack:4/32-34)

On the other hand, Chris describes:

> ‘it’s a big part of who I am but I wouldn’t say it defines who I am’ (Chris:36/22-23)

It appears that Chris internalises BED as part of himself. Possibly Chris views himself as made of many parts, of which BED is one big part. Therefore, Chris views BED as being an aspect of himself rather than all of the self. It can be understood that by not completely internalising BED, Chris does not identify with his BED, which allows him a greater sense of hope and strength in being able to fight his BED.

It appears that these men experience a complex relationship between the self and BED as BED is viewed both as an external feature and also an internalised part of themselves. This may possibly explain the confusion men experience with BED and their ambivalence in change and recovery from BED.

The experience of treatment

This theme encapsulates the participants’ experiences of seeking, accessing and receiving treatment for BED. Through their experiences of treatment the men make recommendations for how BED treatment could be improved to meet their needs.

Seeking and accessing treatment: struggling alone in search of unavailable support

This theme addresses the participants’ struggles in seeking and accessing treatment for BED. The men describe the lack of understanding they experience professionals to have of their BED. They further reveal their sense of isolation in overcoming treatment barriers and in seeking unavailable support.

The participants expressed how they initially misunderstood their BED as being something else which reinforces the lack of information and knowledge in BED and men. Tom initially misunderstood his BED as being a form of diabetes or even greed:

> ‘am I diabetic? Am I just greedy? (Tom:3/28-29)

Sam further describes how he was misunderstood by his mother as being gay due to his BED preoccupation with weight and food. Moreover, he reveals how his BED was misunderstood by his GP:

> ‘I don’t think he understood quite what I was going through (…) like I wasn’t telling the truth’ (Sam:17/9-15)

Sam thought his GP believed his problems with food were imaginary. This could be understood as professionals’ lack of knowledge and understanding of BED in men. Danny also describes how his GP initially misunderstood his weight and food problems, believing them to have other probable causes:

> ‘he thought first I was in the middle of some terrible depression or some kind of episode, a break down’ (Danny:40/23-24)

Having their BED misunderstood as something else perhaps contributes to feelings of confusion, uncertainty and despair in understanding their BED and also contributes to feelings of mistrust towards professionals. Additionally, participants expressed an immense sense of isolation in going through their struggles with BED and in helplessly struggling to find unavailable and inadequate support. This is depicted in Chris’s account:

> ‘I think certainly the lack of support and the lack of information played a major part in always making me aware that there isn’t as much support as you kind of needed or expected to be there’ (Chris:22/4-8)

Additionally, men describe the challenges they encountered in accessing treatment due to a scarcity of treatment options available to men with BED. This is illustrated in Sam's account:

> 'there aren't a lot like discussion groups (…) I haven't heard anything else like that' (Sam:18/32-35)

Participants further express how the stigma attached to men with BED serves as a barrier in seeking treatment. Chris illustrates how stepping forward to seek help is experienced as a self-inflicted stigmatisation:

> 'to actually put yourself forward and say I am not like the rest of the male population (…) it's kind of making yourself even more vulnerable because you then set yourself aside from everybody else' (Chris:26/1-7)

Peter reinforces how the fear of stigma might create a barrier in men seeking help for BED:

> 'guys would suffer longer because they won't come forward, they won't seek therapy because of the stigma' (Peter:5/9-11)

Challenges in receiving treatment

This theme encapsulates men's experiences of receiving treatment of different modalities for BED. Tom describes his experience of CBT group therapy as being 'a nuthouse':

> 'I found therapy at times difficult and on the whole, it has brought me to a much more understanding place (…) I heard a lot of people talk about things like I'm still bingeing regularly (…) and people [were] going on and on and on and I thought stop bingeing, you know at times it was quite frustrating' (Tom:9/15-34)

> ‘[it] started off with everyone wanting to talk and you just sit back and listen to what you thought was a nuthouse’ (Tom:10/7-9)

Tom discusses his frustration in attending group therapy and in listening to people’s problems with EDs. Describing group therapy as ‘a nuthouse’ can be understood as a stereotypical view of mental health issues which historically were treated in asylums. Perhaps what Tom finds so difficult to tolerate in this group is actually what he finds difficult to tolerate in himself; for example, feeling like a nutcase. Finding himself in a therapy group of only female members is overwhelming and frustrating possibly because he struggles enough managing his own feelings without having to take on other people’s problems. Additionally, being the only man may have contributed to feeling less connected in therapy and with the group members. He therefore assumes an observer role, rather than actively participating, therefore deflecting attention from himself which further suggests a possible resistance to treatment.

Danny appears to be experiencing NHS treatment care provision as inadequate as he felt he needed support following person-centered therapy. On his experience of receiving 12 sessions of person-centered therapy Danny describes:

> ‘It’s too scary, too risky to start treatment and discover that the number of sessions, or whatever is prescribed, isn’t enough, so then it had to stop’ (Danny:39/31-37)

Similarly, Chris gives the following account for his experience of receiving 12 sessions of CBT treatment from the NHS:

> ‘making yourself even more vulnerable because you then set yourself aside from everybody else (…); I was given 12 weeks of CBT and then dropped completely so no further communication, no support from the GP, nothing at all’ (Chris:26/5-13)

Danny and Chris describe similar experiences of receiving treatment for their BED. Both describe how 12 sessions of treatment were insufficient to be able to

address their issues with BED. Danny found it ‘scary’ and ‘risky’ to place himself in what he saw as a vulnerable position by seeking treatment and opening up, only to find that the available therapy was not adequate. Similarly, Chris describes his experiences as being ‘dropped’ from therapy and having no other support available. Being ‘dropped’ can be understood as experiencing a sense of abandonment and disappointment especially after experiencing difficulties in accessing treatment, only to discover that the treatment offered was inadequate to treat his BED. Perhaps experiencing their treatment as inadequate can be understood to be a reflection of feeling inadequate as men for having BED.

Additionally, all of the men have sought self-help treatment for their BED. Most of the men describe how going through self-help treatment provided them with a sense of (re)gaining control and competence in overcoming their BED on their own. Peter sought self-help treatment for many years before seeking CBT therapy. His experience of self-help treatment is two-fold:

> ‘this self-help book thing is great cause you can do it in the privacy of your own home (…) I now know that’s not enough, you really need [to see] a therapist; you know books were great for me because I didn’t want to see a therapist until later’ (Peter:22/7-11)

> ‘I am the example of stupidity of all of those years that I waited. I am the person that you should avoid to be, so don’t be like me, go get help now’ (Peter:21/1-3)

Learning about his BED on his own, and in private, provided him with a sense of control and worthiness. As Peter describes, self-help was ‘great’ for him as he was not ready to see a therapist for years into his BED, possibly due to experiencing ambivalence over treatment or fear of stigma. However, he explains how up to a certain point self-help proved to be inadequate and regrets relying on self-help treatment for years instead of seeking therapy. Through urging other men to seek therapy for their BED perhaps Peter is trying to ameliorate his own feelings of regret through the idea of others benefitting from his personal experience.

Treatment focusing on men

This theme emerged on account of how the men felt BED treatment could be improved. Danny and Chris make recommendations for an all-male group therapy:

> 'men are more likely to go when there is going to be eight men sitting around talking about their experiences (…) [this] in itself can overcome stigma and (…) help each other through, I think peer support is massively underestimated' (Danny:38/20-31)

> 'group therapy would be beneficial to not kind of having that isolation, being able to talk to males and guys who have gone through the whole process' (Chris:27/29-28/6)

Both men expressed the belief that having all-male group therapy has a number of benefits as men are more likely to enter treatment if they know other men will be present. They also believe that an all-male group would enable men to reduce the stigma that EDs occur only in women. It can also help to reduce the sense of isolation they experience as men with BED in sharing their experiences with other men. Tom supports this recommendation for all-male group therapy as he states:

> 'my experience [of group therapy] could have benefited [me] slightly more if I was lucky enough to have a couple more guys in there' (Tom:11/7-9)

Sam further recommends the need for both group and individual therapy to be made available to men with BED:

> '[professionals] can start groups (…) or maybe start something like one-to-one counselling sessions [in an] open surgery once a month' (Sam/19/11-16)

Chris makes specific recommendations for the treatment of men with BED:

> ‘that sort of lack of support and empathy again from a male perspective is something that makes it very difficult to sort of tailor treatment towards (…) it may take somebody who’s actually gone through the experience to kind of say well actually this is how it does feel’ (Chris:25/27-35)

Chris suggests there is a need for men to feel more support and empathy for their struggles with BED which treatment needs to take into consideration. He also recommends that more men are needed as role-models to speak up about their struggles with BED. This may lead men with BED to feel more understood, less isolated and stigmatised, and to experience a greater sense of support.

Participants further recommend the need to normalise BED in men in order to enable men to feel more understood and less isolated. This is further illustrated in Chris’s account:

> ‘Break away with that way of thinking with guys. But then to also have the support there to say well actually you are not the only one; it’s not abnormal (…); it’s one of those things that happens with human beings as whole; it’s not a female thing, it’s not a male thing’ (Chris:18/12-20)

Chris expresses the need to normalise BED in men through emphasising that BED can occur in men and women. It can be suggested that Chris recommends that men ‘break away’ from the omnipotent ‘macho male’ stereotype and simply be ‘human beings’. Peter supports Chris’s recommendation for normalising BED as occurring in both men and women:

> ‘[BED] is something that men and women share pretty equally so that would be important for men to learn’(Peter:21/31-32)

Summary

For all participants the experience of BED was described as a divergent experience of negative and positive facets, characterised by a constant struggle to control their bingeing. Living with BED appears to be a constrained life of fear

and vulnerability, further portrayed as living in an inescapable trap. For the participants understanding their BED appears to be a difficult and confusing process. In trying to make sense of their BED, the men compare it to an addiction and also describe BED as serving a function for example, dissociation and affect regulation. For most of the men in this study, suffering from BED is experienced as an immense stigma. They associate BED with women and homosexual men, as men with BED fail to fit into the 'macho male' stereotype they so strongly adhere to. This further impacts their sense of self as being weak. The participants also shared their experiences of seeking, accessing and receiving treatment, where most of the men described their experiences of treatment as inadequate and insufficient. They further contribute recommendations on how to improve BED treatment to address their specific needs.

Chapter 5

Discussion

Overview

The purpose of this study was to explore men's experiences and understanding of BED. These findings illustrate how men with BED share similar experiences to women with BED and men with EDs. However, a number of unique issues pertinent to men with BED are revealed.

This chapter will review the study's findings by contextualising them in existing literature and highlighting the novel issues which emerge from the current study. A discussion of the present study's findings in relation to a number of theoretical models will be presented. The clinical implications of the findings will then be considered, together with the applicability of the findings to CoP and professional practice in this area. A critical evaluation of the present study will then be undertaken, which will consider the study's limitations. This will be followed by recommendations for future research, some final reflections and conclusions.

The experience of BED

The present study provides an insight into men who experience their binge episodes as having a dual facet of positive and negative consequences. The men express the initiation and duration of their binge eating as pleasurable, as it provides them with feelings of comfort and enjoyment. However, these feelings are transformed into negative feelings of regret, shame and disgust at having consumed large quantities of food, having lost control over eating and the consequences this has on their weight and body. This finding is consistent with the existing literature of BED (Fairburn, 1995; 2013) and with studies exploring women's experiences of BED (Owens, 2003; Sandy, 2006; Starkman, 2005). It is also considered consistent with affect regulation theory (Heatherton &

Baumeister, 1991) as the men in this study appear to engage in binge eating in order to regulate negative affect. Binge eating can be understood as serving a valued function for these men in coping with negative feelings, which will be explored below. As no other previous research study has focused on men's experiences with BED, the present study confirms that men experience binge eating episodes in a way similar to that experienced by women.

The dual facet in BED may be understood as men experiencing pros and cons regarding their BED, which may have clinical implications in their motivation for treatment and change. This is consistent with the EDs research indicating pros and cons in AN and BN (Gale, Holliday, Troop, Serpell & Treasure, 2006; Serpell, Teasdale, Troop &Treasure, 2004). A number of similarities can be found between the positive perceptions these men have for their BED and the positive perceptions of individuals with EDs, for example, coping with boredom and shifting emotions. Additionally, these men with BED share similar negative perceptions with other individuals with EDs for example, having a negative self-image, weight and shape concerns and feeling trapped.

Interestingly, the men in this study appear to hold distinct positive perceptions in having BED, not found in previous research specifically exploring pros and cons of EDs. There appears to be a strong association with positive feelings such as enjoyment, pleasure, love, nurture, as well as coping with loneliness and anxiety. Previous research findings have shown positive views associated with having an ED in feeling safe/structured, feeling special and being able to eat but stay slim (Gale et al., 2006; Serpell et al., 2004; Serpell & Treasure, 2002). These positive views were not found in these men with BED.

The men in this study also appear to hold a negative perception of their BED which is slightly different to other individuals with EDs. These men described associating guilt with their BED as they felt guilty for the large quantities of food they consumed and for the damage caused on their bodies and weight. Guilt was also found to be a con in previous research studies (Gale et al., 2006) but was associated with feeling guilty for the worry caused by their ED to friends and family, which was not found in these men with BED. Possibly these men experience a number of distinct pros and cons in having BED, which may be useful to take into account in the treatment of men with BED.

Most men described how receiving a BED diagnosis was experienced as a useless label; whereas others described how receiving a diagnosis provided them with an understanding of their struggles. It appears that the men in this study describe both the potential utility as well as the negative consequences of receiving a diagnosis. Similarly, there are conflicting views within CoP in relation to the use of diagnostic categories. It is recognised that there are potential utilities of a diagnosis as possibly providing 'a reference point from which standardised modalities of treatment begin' (Milton, Craven & Coyle, 2010, p.61). Milton et al. (2010) contribute towards the ongoing debate of psychopathology and CoP. They suggest that using psychological formulations enables to assess and work with psychological differences in a 'non-pathology-oriented means' and therefore negotiating 'the meaning of psychological distress between therapist and client' (p.68).

The men in this study expressed their futile struggles in controlling their binge eating and their subsequent experience of an intense sense of loss of self-control. Loss of control over self and eating appears to be a central feature of BED as found in the existing literature (Colles, Dixon & O'Brien, 2008; Fairburn, 1995; 2013). Studies exploring women's experiences of BED have also reported a sense of loss of control (Owens, 2003; Sandy, 2006). The loss of control experienced in BED can be understood in relation to restraint theory which suggests that binge eating results from a disruption to the restriction of food implemented in an attempt to control food consumption and weight (Polivy & Herman, 1999).

Participants also described binge eating as frenzy, reinforcing the strong sense of loss of self-control over eating. These men possibly experience binge eating as an intense moment of craziness. This is reflected in studies describing binge eating as a chaotic behaviour (Hagan et al., 2002; Wilfley et al., 2003) which supports participants' description of binge eating as 'manic', 'insane' and 'crazy'. Men also describe experiencing a strong sense of dissociation during binge eating, from their thoughts, feelings and from the actual binge episode. The experience of dissociation is a common phenomenon reported by individuals with EDs particularly those engaging in binge eating (Everill, Waller &Macdonald, 1995; Mountford, 2013) and is consistent with studies exploring women's experiences of BED (Owens, 2003; Starkman, 2005).

The present study supports previous research studies in women with BED by illustrating that the loss of control and dissociation features are experienced by both men and women in a similar way. However, this study suggests that men's experiences of loss of control may also be different from women's experiences. The current study illustrates that losing self-control and failing to control their eating as men, evokes feelings of shame, weakness and emasculation. This is consistent with studies linking masculinity in men with control, power and strength (de Visser, Smith & McDonnell, 2009). As such, the feelings of emasculation due to the loss of control over self and eating, which the men in the present study experience, appears to be a unique issue in men with BED, not present in women with BED.

The men in the present study conveyed their experiences of living with BED as living a constrained and impaired life of shame and vulnerability. Similarities can be drawn between the present study's findings and those of de Beer (2009). He found how men experience living with AN and BN as living a paused and damaged life and being constantly vigilant towards triggers and relapse. However, the current study expands on these findings as it specifically illustrates how men experience living with BED. The present study's findings on men's experiences of living with BED are considered consistent with studies exploring the quality of life of individuals with BED. These studies show impaired functioning and poor physical health in women (Johnson, Spitzer & Williams, 2001) and in women and men (Masheb & Grilo, 2004; Rieger, Wilfley, Stein, Marino & Crow, 2005). However, these studies associated the poor quality of life with the psychological and physical impact of obesity resulting from binge eating. The present study illustrates men's experiences of living with BED, irrespective of their weight.

This study illuminates men's experiences of living with BED as isolating. This may be due to the secrecy element of BED due to stigma, which will be explored below. This strong sense of isolation may also be due to not knowing other men with BED either through acquaintance or known cases. This is in contrast with men with AN and BN, as there are numerous documented cases, books and information of these men's struggles (Grahl, 2007; Morgan & Marsh, 2006; Simon, 2006).The isolation these men experience appears to be a unique and novel issue pertinent to men with BED.

The process of understanding

The men in this study described the process of understanding their BED as difficult as they cannot explain why they engage in binge eating. Some highlighted this process as a turbulent quest, as they were left to question their emerging understandings. Participants described divergent understandings, with some men considering BED as addiction to food. However, all men appeared to be experiencing a great sense of confusion and uncertainty in their struggles to understand BED. This sense of confusion is also evident in some men who described experiencing positive consequences, such as BED being a source of comfort and having a protective function, as well as experiencing negative consequences such as guilt, shame and weight gain for binge eating. This sense of ambivalence and confusion may have clinical implications in some men's motivation for treatment and change in their BED.

Some men expressed their understanding of BED as comparable to an addiction, which is consistent with the addictions model (Wilson, 1991). However, it appears that men compare their BED to addictions in their effort to make sense of their binge eating as they can more easily relate to addictions than BED. They do not necessarily present BED as an addiction disorder, an argument supported by studies comparing BED and addiction in women (Cassin & von Ranson, 2007). These men appear to emphasise a reward mechanism being in place for binge eating, similar to the reward mechanism associated with abusing drugs and alcohol. The present study therefore confirms that some men might understand their BED as being similar to an addiction.

Additionally, the men in this study appear to understand their BED as serving a function. Men describe how binge eating allows them to dissociate from their thoughts and feelings and from the actual experience of binge eating. It appears that the experience of dissociation during binge eating also serves as a temporary coping and protective mechanism from negative thoughts, feelings and concerns which these men have. The experience of dissociation is usually thought of as a reflection and way of coping with trauma which studies exploring women's experiences of BED have shown for example, bulling, sexual and physical abuse (Owens, 2003; Starkman, 2005). This is also supported by the

existing literature in EDs and men (Connors & Worse, 1993; Strother et al., 2012) which suggests that trauma in men is a risk factor in developing an ED. In the present study only one out of the six men described what can be speculated as trauma as he grew up in a very strict family environment with a physically abusive father. It can be argued then that the experience of dissociation in some men with BED might be an indication of trauma which might have clinical implications in their motivation for treatment and ambivalence in changing what might be perceived to be a coping mechanism.

Additionally, men describe binge eating as serving as a means of coping with and regulating negative emotions such as anxiety, loneliness, boredom and stress, which is consistent with the affect regulation model. Binford, Mussell, Peterson, Crow and Mitchell (2004) provided evidence of the functional aspect of binge eating in BED as affect regulation; however, they only looked at women with BED. The functionality of EDs has been found in research in men with AN and BN (de Beer, 2009). de Beer described how men experience the function of their ED in 'resolving psychological crises'; for example, functioning as a source of comfort, self-improvement and punishment. The study does not explore the significance of this theme in men's experiences of EDs as de Beer focused on selective themes in his discussion section. The current study can therefore be seen to expand upon the previous studies conducted on the functionality of BED in women or EDs in men and confirms that some men might also understand their BED as serving a function and more specifically serving as dissociation and affect regulation functions.

The stigmatised self

The men in this study expressed divergent and convergent experiences of the stigma experienced due to having BED. They described BED as associated with women and/or homosexual men, highlighting the stigma of men having BED. They also highlighted the stigma of having a disease seldom associated with men, and of being perceived as weak, greedy and liars. Men with BED further experience the stigma of not adhering to the strong male stereotypes

which they associate with masculinity and muscularity. This in turn affects their sense of self as being flawed and less masculine.

In this study men discussed a number of stereotypes of being a 'macho male' man, which they strongly adhere to in defining their sense of self as men. This can be understood through the dominant concept of 'hegemonic masculinity' (Connell, 2005). Hegemonic masculinity is displayed through certain behaviours such as physical and emotional strength, competitiveness and heterosexuality (de Visser et al., 2009) and is also associated with physical competence in sports and alcohol consumption (de Visser & Smith, 2006; 2007).

Previous research studies has showed that masculinity is associated with muscularity in men (McCreary, Saucier & Courtenay, 2005; Olivardia et al., 2004), which is strongly depicted in the present study as participants describe striving for a thin and muscular physique. The present study suggests that men's sense of muscularity is damaged by BED as these men inevitably gain weight through binge eating and not engaging in any weight compensatory behaviours. Gaining weight damages their ideal muscular physique therefore reinforcing feelings of emasculation. This appears to be a unique issue in men with BED, not evident in previous studies of EDs.

The men in this study also highlighted their engagement in hobbies/professions associated with physical activities; for example, joining the royal marines and being part of sports teams. Studies illustrate how certain professions and sports/hobbies that require physical strength have been associated with muscularity, which has come to embody the masculinity men aspire to (Beagan &Saunders, 2005). Furthermore, there appears to be social pressures in conforming to these stereotypes in order to be perceived as masculine. Not engaging in such male behaviours might lead to being marginalised by peers (Drummond, 2002) and stigmatised as having a flawed masculinity (de Visser & McDonnell, 2013).

As no other research study has specifically explored men's experiences with BED, the present study confirms that men with BED, similar to men with AN and BN, experience stigma as they associate BED with being a 'female thing'. The stigma in men with EDs has been found in a number of studies (e.g. Drummond, 2002) as men have been found to associate AN and BN with women, further reinforced by the strong skewed prevalence of EDs in women (Striegel-

Moore & Bulik, 2007). Interestingly, despite findings that BED affects fairly equally both men and women (Muise et al., 2003), this study suggests that men appear to associate BED with EDs and therefore with a female disorder. This could be understood in two ways. On the one hand, the association of EDs as 'female disorders' is possibly so strong and pervasive, which is endorsed by men with BED, despite findings showing equal prevalence. On the other hand, the men in this study highlight the lack of information available to men regarding BED. It could therefore be suggested that men with BED are not aware that BED affects fairly equally both men and women, and continue to perceive BED as a 'female thing'. This is further reinforced by the fact that only one of six participants was aware of this prevalence finding.

The participants also experience stigma as they associate their BED as being a 'gay thing', further reinforcing their sense of emasculation. This is also found in EDs studies in men (de Beer, 2009). Masculinity is strongly associated with heterosexuality; homosexuality is therefore equated with emasculation and femininity. EDs are linked with homosexuality as gay men are perceived to focus more on appearance, weight and body (Boisvert & Harrell, 2009; Feldman & Meyer, 2007). In the present study one out of the six men identified himself as homosexual. He described how all men regardless of their sexuality idealise a thin and muscular physique. He expressed, however, that homosexual men are under a greater pressure to fit into these ideals as the homosexual community places a greater emphasis on physical appearance. The participant also described how his gender was a more important issue, than his sexuality, in affecting his experiences with BED, as he experienced stigma and isolation for having a female disorder. The present study supports that men irrespective of their sexuality can suffer from BED, and heterosexual and homosexual men may experience stigma for their BED as they associate it with women and/or homosexual men.

Qualitative studies conducted on men's experience of AN and BN show men experiencing a 'flawed sense of masculinity' (Drummond, 1999; 2002) and perceiving themselves to be 'less than male' (de Beer, 2009). This is similar to the present study in which men express their sense of self as weak, flawed and incompetent. Referring to the hegemonic masculinity described above, it can be understood that men with BED perceive themselves as not fitting in with the

male stereotype of being 'macho male' men, therefore rendering them to being less than male and emasculated by their BED. This stigmatisation exacerbates feelings of shame and embarrassment, reinforcing their sense of isolation and acting as a help-seeking barrier.

Shame in EDs is usually associated with the quantity of food consumed and with body weight and shape (Andrews, Qian & Valentine, 2002; Skarderud, 2007). The present study supports these findings as these men with BED experienced shame mainly for consuming large quantities of food and to some extent for gaining weight and adding to their stretch marks. However, studies exploring shame in women with EDs suggest that there are additional sources of shame in EDs, for example, shame about achievement failures, self-control, having an eating disorder, social isolation and bullying (Keith, Gillanders & Simpson, 2009; Skarderud, 2007). The present study expands upon existing literature on different sources of shame in EDs and suggests that the men in this study appear to experience unique sources of shame in relation to their BED. The concept of shame in these men appears to be associated with masculinity. More specifically, they appear to experience shame in relation to losing control over self and eating and therefore failing to control their selves as men. They also appear to experience shame for having BED which they perceive to be 'a female disorder' and therefore affecting their sense of masculinity. Addressing the different sources of shame in men with BED is considered to be clinically relevant as it can affect motivation for treatment as well as disclosure which can impact the therapeutic relationship and treatment outcome (Swan & Andrews, 2003).

The men in this study described divergent understandings regarding stereotypes of eating and food. Some participants reveal experiencing stigmatisation of character due to BED as they feel they are perceived as weak and greedy because they lack self-control and overeat. This appears to be consistent with the weight bias stigma as overconsumption of food is regarded as a lack of self-discipline, as being greedy and morally weak (Hebl & Turchin, 2005; Puhl, Moss-Racusin & Schwartz, 2007). The present study suggests that men not only experience stigma for having BED as being a female and/or homosexual disorder but also experience additional stigmatisation of character. This suggests the immense difficulties men with BED are faced with in

overcoming these different types of stigma which act as treatment seeking barriers.

In contrast, other participants expressed adhering to eating behaviour stereotypes which they strongly associate with masculinity. For example, eating large quantities of food is associated with masculinity (Vartanian, Herman &Polivy, 2007) and certain types of food for example meat, are considered to be masculine foods (Herman & Polivy, 2010). This is exemplified through Jack's account as he describes eating steaks and ribs to reinforce his sense of self as masculine.

The male stereotypes of eating behaviours may establish binge eating as an acceptable male behaviour, which appears to be a unique finding in men with BED. Furthermore these male stereotypes of eating behaviours can prevent men from recognising their binge eating as problematic. Men might also adhere to these stereotypes to hide or possibly deny their BED. This is illustrated in some men's accounts as they described how it is acceptable for men to eat a lot but it is not acceptable to have an ED. This further highlights the immense difficulty in men to recognise and accept their eating behaviours as BED.

The experience of treatment

The men in the current study expressed their struggles in seeking and accessing treatment. They highlighted the lack of knowledge and understanding of BED by GPs, a finding supported by Henderson et al. (2003). They described how their BED was initially misunderstood by their GPs as having other probable causes, for example depression. The lack of recognition of EDs by GPs has been reported elsewhere in men (Copperman, 2000) and in both men and women (Reid, Williams & Hammersley, 2010). This lack of knowledge is further reflected in men, for initially they even misunderstood their BED with diabetes or other weight issues.

Participants also highlighted the challenges they experienced accessing treatment due to the scarcity of treatment options available to men with BED. The men expressed feeling isolated as they sought support and information which were unavailable. This study highlights the need to inform professional

practice and to expand the knowledge and understanding of BED in men. It also highlights the need for more services which may provide treatment to men with BED.

These men further illustrated the challenges they experienced in receiving treatment for BED such as individual, group CBT and person-centered therapy. Participants described receiving inadequate and insufficient treatment for their BED from the NHS. They described how they were offered limited treatment care options such as 12 sessions of therapy, which they experienced as inadequate. They further expressed not having any available support or communication following their course of therapy. Previous research studies exploring men's experiences of receiving treatment for AN and BN have also showed men's dissatisfaction with the treatment they received, problems with the identification of the ED and not being understood or cared for by professionals (Copperman, 2000; de Beer, 2009; Drummond, 1999, 2002; Robinson et al., 2013).As no other previous research has focused on men's experiences of treatment for BED, the present study suggests that some men's experiences of receiving treatment for BED might be similar to the experiences of men receiving treatment for AN and BN.

All the participants engaged in self-help treatment for their BED. Self-help treatment provided them with a sense of self-control and self-worth in combating their BED on their own and in private. Self-help treatment may enable men to avoid seeking and accessing treatment, a difficult process which forces them to admit to having BED and the risk of being stigmatised. However, participants also expressed the disadvantages of self-help treatment as it did not help them overcome their struggles and may have led them to not admitting to having BED. The men in the current study make recommendations towards improving treatment in men with BED, which will be addressed below in relation to recommendations to professional practice and CoP.

Discussion of findings in relation to theoretical models

The findings of this study appear to be consistent with a number of theories of BED. The findings appear to be most relevant to the affect regulation theory of BED as these men appear to binge eat in order to regulate and cope with negative affect for example, anxiety, loneliness and boredom. The role of emotions appears to be important in these men with BED, which is a key feature in a number of theories.

Cognitive behavioural theories suggest that some individuals may have difficulties tolerating intense and adverse moods. Individuals with mood intolerance may not have acquired skills to tolerate negative mood and use food in order to regulate their emotions (Fairburn. 2008). Low self-esteem, a key feature in cognitive behavioural theories, also appears to be present in these men as they view their selves as weak, fragile, incompetent and flawed. The study's findings suggest that possibly these men have low self-esteem and a negative perception of their selves, which engaging in binge eating further exacerbates, and therefore maintains their BED. As a result a possible link can be speculated between low self-esteem and the development of a reliance on food as a method of coping with and regulating negative affect.

The role of low self-esteem and negative affect is also a key feature in escape theory. The men in this study describe how they view themselves as weak and flawed which can be related to an aversive self-awareness as put forward by the escape theory. These men set high expectations of themselves by idealising a thin and muscular physique and wanting to become 'macho male' men. For some men such high expectations are unattainable, as they cannot control or stop themselves from binge eating and gaining weight. As a result they develop a view of themselves as inadequate and even as a failure. In order to escape from such an aversive self-awareness and from negative affect they result to binge eating which, as these men describe, creates a desirable 'vacuum' which helps them to escape from their own feelings, thoughts and even from the actual binge eating experience.

The present study's findings appear to be in conflict with the restraint theory. None of the men in this study described actively dieting or restraining food in order to lose weight, which is in line with existing literature suggesting

that mostly women are concerned with weight whereas men are more concerned with muscles. However, the men in this study did describe having weight struggles for an extensive period of their lives. They viewed their relationship with food as dysfunctional and unhealthy and described repeated failed attempts to healthy eating. Some of the men described that after eating 'bad' or 'unhealthy' food they engaged in disinhibited eating. This led to elevated negative mood and together with failed attempts to control eating then led to binge eating. Therefore the study's findings appear to provide some support to the restraint theory.

The present study's findings can be linked to the addictions model which suggests that addictive behaviours are endorsed in order to increase positive feelings. The men described their positive views of BED as providing them with pleasure, enjoyment and comfort. Additionally, negative emotional tolerance and regulation are also common features in addictions and in men with BED. However, it can be argued that eating is similar to other addictions such as gambling or shopping where it's the activity itself that is rewarding and reinforcing (Davis & Carter, 2009). The men in this study do not view their BED as an addiction, rather they compare their BED to addictions in an effort to make sense of what is happening to them. It can be argued that categorising BED as an addiction may have negative undesirable consequences for example, individuals may experience additional stigma for having an addiction or being perceived to be 'addicts'. It may also contribute to feelings of despair and hopelessness as it is impossible to completely abstain from food and therefore making recovery impossible. Therefore the present study supports the argument proposed by a number of studies that BED is best not perceived to be an addiction disorder (Cassin & von Ranson, 2007).

Overall the study's findings can be linked to a number of theories, but it appears to be more consistent with the affect regulation theory. As Wallace (2013) suggests, the role of emotion regulation in BED appears to be important both in the development and maintenance of BED and suggests considering an integration of these models in order to adequately address the psychological processes involved in BED. The role of emotions in BED can have important clinical implications for example, having to address deficits in ability to manage, tolerate and regulate emotions; find alternative sources of comfort and pleasure

and more effective coping strategies. The next section will specifically address recommendations to professional practice and CoP.

Clinical implications and applicability to CoP practice

The present study has identified various potential recommendations for the treatment of men with BED, suggested by participants. These recommendations will be explored, in addition to how they might be applied to professional practice and thus inform counselling psychologists. Spivak & Willig (2010) suggest that it is important to listen to individuals' needs and recommendations in order to improve treatment provision. They suggest that this corresponds to the CoP values of 'listening to our clients to determine the best way forwards' (p.8). A number of the recommendations made for the treatment of BED in men support the existing clinical literature in working with men with EDs. However, due to the evident lack of information and knowledge of men's experiences and needs in the treatment of BED, the recommendations made here are considered valuable contributions in providing a deeper understanding of where the treatment needs of men with BED and other EDs overlap and which are the specific treatment needs recommended for men with BED.

In light of the present study's findings, it is suggested that counselling psychologists need to extend their knowledge of BED in men to better inform their practice and tailor treatment to meet men's specific needs. Extending their knowledge of BED in men, counselling psychologists will be able to share this information with their male clients. Providing psycho-education for men experiencing BED is considered to be important, as this study highlights men's struggles in trying to understand their BED as they described feeling mistrust and disappointment towards professionals who did not understand their BED. By helping these men understand their BED, and showing that they understand the particularities of their disorder, counselling psychologists may provide them with a greater sense of motivation to engage in treatment. This may significantly contribute to building a therapeutic relationship in which men feel supported and heard. Additionally, counselling psychologists need to inform men of the prevalence of BED as being fairly equal in men and in women. This can assist in

dispelling the stigma associated with BED as a female disorder and normalise BED in men.

Raising awareness is imperative in dispelling any misunderstanding surrounding BED and in helping men recognise their BED in order to seek treatment. A possible suggestion is for counselling psychologists to raise awareness in BED in their workplace such as an educational setting; a suggestion supported by literature in men with EDs (Copperman, 2000; Mussell, Binford & Fulkerson, 2000). The current study also suggests problems with the identification of BED in men by professionals, which can delay referrals to specialist treatment services. It is therefore considered imperative to inform and possibly train professional practitioners to further recognise and understand BED in men.

The current study highlights the explicit female-focus in BED in services, both in terms of treatment and available information. It is therefore recommended for services providing treatment for BED to have a gender-sensitive focus. Counselling psychologists are advised to be mindful of female pronouns in the literature material they provide, and efforts should be made to alter these, for example reprint them with a gender-sensitive focus. This suggestion is also supported by literature in men with EDs (de Beer & Wren, 2012). Furthermore, counselling psychologists should be aware of reading material which addresses EDs in men, in order to recommend them to men with BED (Morgan, 2008; Paterson, 2004; Pope et al., 2002; Saxen, 2007). This could possibly assist in making men feel more understood and supported and in normalising BED in men.

The present study illustrates the functionality BED serves in terms of dissociation and affect regulation, which may have important clinical implications. BED appears to have a positive function; it becomes a coping mechanism which men might be reluctant to change. Counselling psychologists need to become aware of the functionality of BED in men as it can affect men's engagement in treatment. The functionality of BED may also serve as a maintaining factor of binge eating in men, providing an explanation for any possible issues of ambivalence and resistance to treatment. Understanding this functionality can help counselling psychologists to greatly understand and

empathise with the difficulties these men face in changing their eating behaviours which can make men feel more understood and supported.

Counselling psychologists are advised to utilise supervision, in order to become more aware of their assumptions towards men with BED and the stereotypes associated with eating behaviours regarding masculinity and food. In this way assumptions and biases do not impinge on the therapeutic process, further facilitating empathy and congruence towards men with BED. Counselling psychologists should address male eating stereotypes in treatment to help men recognise their eating habits as problematic and distinguish between binge eating and socially acceptable male overeating. This could possible help in breaking the association between overeating and masculinity.

This study highlights the pervasive male stereotypes of being 'macho male' men, which participants adhere to. Men associate BED with women and/or gay men therefore failing to fit in the masculine stereotypes. It is recommended that counselling psychologists be aware of male stereotypes and address them in therapy, where relevant, in order to address issues of emasculation and stigma. Addressing issues of emasculation and stigma is also supported by the literature in men with EDs (Greenberg & Schoen, 2008; Strother et al., 2012). Additionally, counselling psychologists are advised to be cautious not to make assumptions of the sexuality of men seeking treatment, as this study supports that BED occurs in men irrespective of sexuality.

Men with BED appear to idealise a thin and muscular physique, which is associated with masculinity, as this study highlights. Striving to achieve such an unattainable physique may work as a maintaining factor for BED. It is therefore considered important for counselling psychologists to address body image and dissatisfaction in the treatment of men with BED. Weight loss should also be addressed, if deemed necessary, as men with BED who seek treatment may experience weight problems. Failure to address these issues may lead men to engage in unhealthy weight loss or exercise regimes following treatment, which could trigger binge eating. This is supported by Weltzin et al. (2012) who recommend addressing body image and exercise behaviour issues in men's treatment of EDs in order to enable men to differentiate between a healthy physique and a thin/muscular idealised physique.

Men in the present study recommend all-male group therapy and/or discussion groups for BED, which appears to have important clinical implications. An all-male group setting may enable men to overcome the stigma of associating their BED as a 'female thing'. Additionally, it may address their sense of isolation, as men described not knowing other men with BED, which can provide them with peer support. Men further expressed seeking inspiration from male role-models who are recovering or have recovered from BED. A group of men with BED may serve as an inspiration and motivation in recovery. Weltzin et al. (2012) explored treatment issues in men with EDs and they strongly recommend a male-only group. However, the researchers included 111 men with EDs and only 6 men were reported as having BED. The present study therefore expands upon these findings by highlighting the benefits of all-male group therapy for treatment for men with BED.

The men in this study expressed the need to feel a greater sense of empathy and support from professionals during and after their BED treatment. This finding is consistent with EDs research as Robinson et al. (2013) found men with EDs expressed a need to feel understood and cared for by professionals during treatment; a finding also emerging from studies in women with EDs (Reid, Burr, Williams & Hammersley, 2008). This study therefore recommends the provision of support to men with BED during treatment and following completion of treatment in the form of follow-up sessions, information on charities which provide support for men with EDs, open access support groups in the area and as well as urging GPs to follow up with these individuals. Counselling psychologists and professional practitioners are advised to show empathy and respect towards these men as for most of them the decision to seek help has been difficult which they may have delayed for years. Additionally, counselling psychologists are further alerted to the importance of building a strong therapeutic relationship and alliance with these men through empathy and support, which is a fundamental aspect of CoP.

The lack of support or empathy these men experienced from their therapists could possibly be understood through the psychoanalytic understanding of transference (Lemma, 2003). Perhaps these men experienced their caregivers as unsupportive and unloving and in turn therapists are viewed as unsupportive parental figures which fail to fulfill these men's needs. This could

suggest the underlying difficulties in building strong therapeutic relationships, further alerting counselling psychologists and professional practitioners to be aware of such issues in therapy.

The present research has sought to inform professional practice and CoP of numerous recommendations in improving the treatment offered to men with BED. As counselling psychologists it is important to adhere to our profession's values in respecting each individual's experiences and tailoring treatment to address each man's individual needs in the treatment of BED.

Limitations and suggestions for future research

The present study explored six men's experiences and understanding of BED. Adhering to IPA's idiographic emphasis (Smith et al., 2009), this study does not make generalisations about all men's experiences with BED; it rather offers a valuable contribution to the limited knowledge base of men with BED. Furthermore, adhering to IPA's hermeneutic feature (Smith et al., 2009), it is emphasised that findings resulted from the researcher's interpretations and efforts to make sense of how these men understand their experiences of BED. Thus, other researchers might have derived different themes from the data.

A further possible consideration involves the participation criterion as participants were required to have been in treatment for BED for over a year. This criterion was applied in order to ensure homogeneity across participants' experiences with treatment. All of the participants had more than one year's experience of treatment given their long-term struggles with BED and their extensive self-help treatment. However, this criterion is not considered to be plausible as most treatment modalities for BED are structured between 12 to 24 sessions offered by the NHS or privately. Whilst this criterion could be considered a limitation as it might have prevented more men from expressing interest, it is emphasised that all interested individuals fulfilled this criterion. A recommendation for future research is to recruit men at specific intervals in their treatment for BED.

Another possible limitation lays in participants' struggles with BED, which varied in duration between 2 to 20 years. This wide duration could

possibly have an impact on men's experiences and understanding of BED. Therefore, a suggestion for future research is to recruit men with similar duration of their BED. However, it is noted that since this group is very difficult to recruit, imposing such a criterion might minimise recruitment. It is also taken into consideration that being interviewed by a female researcher may have had some effect on men's disclosure. However, one participant expressed relief that the researcher was a woman as he described feeling uncomfortable expressing his difficulties with BED to another man, in fear of being judged. Additionally, participants were White males, however the exact details of their ethnic identity was not measured, which is another limitation of the present study.

There are a number of suggestions for future research in the area of men and BED, given the limited research and knowledge base in this area. The present study is the first study exploring men's experiences and understanding of BED. Replicating this study may be useful in strengthening the study's findings and contributing further to this under-researched area. It could also be useful to replicate this study with men who have recovered from BED, rather than being in treatment. This could inform counselling psychologists and other allied health professionals about how these men overcame barriers of isolation and stigma in their treatment, which may be useful to implement in their practices.

Some of the themes that were excluded from the final analysis, due to relatively low prevalence and clarity levels in the transcripts (as discussed on p.46 of the analytic process) may nonetheless provide potentially interesting avenues for further research. An area for further research would be looking into the developmental aspect of BED in men as found in some excluded themes: 'early life experiences in developing dysfunctional eating' and 'early life influence on relationship with food'. Some men described how their problems with binge eating originated in their childhood and adolescence. They recalled early life experiences which they believe have played a causal role in developing BED, for example, being forced to eat everything on their plate and not allowed to eat what they desired. It is important to develop our understanding of what are the possible factors that contribute to the development of BED as any perceived causal factors may also act as maintaining factors for BED, for example a traumatic early life experience or dysfunctional relationship with food. This has important clinical implications as addressing causal and maintaining factors can

enhance treatment and recovery from BED. Additionally, it may help professionals to develop more effective prevention plans for BED.

Another avenue for further research is to explore issues of weight and body in men with BED as illustrated in some excluded themes: 'body dissatisfaction' and 'the body as perceived and lived'. These themes refer to some men's negative perceptions of their weight and body. For example, one participant described how he never liked his body and never had a healthy relationship with his body. This is an interesting area to explore as men's relationship with their weight and body can impact their self-esteem and attempts for dieting or excessive exercising in order to enhance their body physiques and lose weight. Addressing issues of weight and body in treatment is important as these may act as causal or maintaining factors of BED in men.

Another avenue for further research is the quantity of food consumed by men with BED as illustrated in some excluded themes: 'large quantity and accessibility to forbidden food'. This refers to eating large and excessive quantities of food they can easily access for example, fast food, as well as, eating certain types of food during binge episodes referred to as 'forbidden food' for example, sweets or bread. This is an interesting area to explore in order to further develop our understanding of the particularities of binge episodes in men with BED. Part of recovering from BED and EDs is developing healthy and regular eating therefore issues of portions, food quantities and food 'rules' need to be addressed in treatment as these may act as maintaining factors for BED.

This study has highlighted the issue of masculinity in men with BED. A further qualitative study in exploring and understanding this issue in detail in men with BED could be beneficial. Another suggestion for future research in this area is to explore men's experiences of BED across cultures, as at present ethnic minorities are under-researched in the area of EDs. It would be interesting to explore whether there is any cultural impact on men's experiences with BED and to further inform professional practice. Such research could be valuable to counselling psychologists as they work with culturally diverse populations.

Final reflections

Conducting this research has been a difficult learning journey, of becoming and transforming (Etherington, 2004). I aspire to what Carl Rogers refers to as immersing ourselves as researchers in phenomena under study and 'this means a tolerance for ambiguity and contradiction, a resistance for closure, the valuing of unbridled curiosity' (Rogers, in Kirschenbaum & Henderson, 1996, p. 269). The process of research taught me to tolerate contradictions and uncertainties, and to embrace my 'unbridled curiosity' in how men experience BED.

As I have come to the end of this research process I have realised that I held a strong assumption throughout the research that men's experiences of BED would be complex and difficult. This assumption has only truly become clear to me through my developing understanding of men's experiences of BED and upholding a reflexive stance through my supervisor's guidance. This assumption possibly occurred because of the difficulty, and therefore complexities, I faced in going through an extensive amount of literature to only find a limited amount of information that could be utilised in both my practice and research with men with BED. Another possibility is that the difficulties I faced in recruiting participants gave rise to this assumption as I subsequently assumed that men would be reluctant to come forward and share their experiences as these are complex and difficult. This demonstrates how engaging in reflexivity 'can give voice to those [assumptions] normally silenced' (Finlay, 2002b, p.541).

I found reflexivity during the analysis process to be immensely important as it allowed me to develop my reflexive stance and to grasp IPA's notion of a hermeneutic circle (Smith, 2007). As I was analysing each transcript, thoughts and reflections emerged for that particular case and for the research as a whole. Using reflexivity also enabled me to adhere to IPA's notion of convergence and divergence (Smith, 2011), as at times analysing a case triggered thoughts as to how each case shared similarities or differences with another. Writing these down in the reflective diary allowed me to express my emerging ideas and also to bracket them in order not to impinge on the analysis process.

Conducting this research study I realised how there are real-life tensions between research findings and implementing these in practice, which contributed to my own learning and development as a counselling psychologist. One such challenge is implementing the all-male group therapy recommendation as the men presenting for treatment for BED are few in numbers in order for services to offer such treatment. As a counselling psychologist I believe it's important to 'apply' our profession's values in both research and practice (Cooper, 2009). We need to embrace working with complexities (Kasket, 2012) and constantly find ways to balance and negotiate real-life tensions in research and practice. A possible recommendation is for services to take on the initiative and offer an all-male group therapy, irrespective of the numbers of men at their service. In this way the services can communicate to these men that we understand the particularities of BED and we recognise the needs of men with BED. As one of the participants has said, if group therapy for men was offered, then more men would come forward. This initiative can also be taken on by EDs organisations and offer all–male support groups, which can further help to raise awareness of these men's needs in services providing treatment for EDs.

Many of the participants expressed their gratitude towards this research and they were also appreciative of the opportunity to voice their experiences. The men's enthusiasm was a great inspiration and motivation for me to complete this research. They have enabled me, and hopefully other counselling psychologists and mental health practitioners, to better understand the struggles men with BED face. This better understanding can help implement findings and improve treatment provided to these men.

Conclusion

The present study's findings appear to provide a significant contribution to the EDs field and especially to BED area. These findings complement and enhance existing literature in this area and can inform and enhance the work of counselling psychologists and mental health professionals with men with BED. The findings that have emerged from this study can be summarised in two main general arguments.

Firstly, the men in this study appear to experience BED in a similar way as to women with BED and men with EDs. For example, these men described experiencing both positive and negative facets of BED, characterised by a constant struggle to control their selves and eating. They also described experiencing the actual episodes of binge eating as intensive, chaotic and crazy. For these men understanding their BED appears to be a difficult and confusing process. In trying to make sense of their BED, they compare it to an addiction and also describe BED as serving a function in their lives for example, dissociation and affect regulation. Having BED is experienced as an immense stigma as they associate BED with women and/or homosexual men. As men with BED they describe how they fail to fit into the 'macho male' stereotypes they so strongly adhere to. This in turn impacts their sense of self as being weak, flawed and damaged as men. They also described their experiences of seeking, accessing and receiving treatment which they described as inadequate and insufficient.

Secondly and most importantly, these men also appear to experience BED in a different way than women with BED and men with EDs, which constitutes the study's originality and contribution to the field of BED and men. More specifically, some men experience a great sense of emasculation and shame for not being able to control their selves and eating as men. Men with BN might also experience emasculation over their binge eating, however they actually describe regaining a sense of control and masculinity through purging or exercising (Fairburn, 1995), which is not present in these men with BED.

All of the men in this study associate masculinity with muscularity and described wanting an ideal body physique of thinness and muscles which they believe portrays a 'macho male' man. Most men with BED inevitably gain weight from binge eating and not engaging in any other weight compensatory behaviours. This contributes to feelings of shame and failure. As a result the ideal macho male physique becomes unattainable and therefore affects their sense of masculinity. Additionally, this study suggests that possibly these men with BED experience unique sources of shame, mainly associated with masculinity.

The men in this study describe how they regard overeating, eating a lot and binge eating as an acceptable 'manly' behaviour. Following such male eating behaviour stereotypes appears to enable men to conceal or deny their BED. This

in turn can create feelings of confusion and ambivalence over recognising and accepting their binge eating as problematic. Additionally, for these men living with BED appears to be a constrained life similar to an inescapable trap. Previous studies on men and women with EDs associate poor quality of life with body weight. However, it can be argued that for these men their lives are impaired by BED regardless of their body weight.

All the men in this study described a great sense of isolation as men living with BED which affects their sense of self as damaged and weak men. They described that even if they know a few other men with EDs they don't know any other men with BED. This is reflected in the literature as there are more books, biographies, websites, articles and information on men with BN and AN than men with BED.

In summary, this research not only contributes to a limited research base but also highlights how some men with BED might actually experience and understand BED in a different and unique way than women with BED and men with EDs. Hopefully this research will help professionals in their work with men with BED and pave the way for further essential research to be conducted in this area.

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Appendices

Appendix A: Recruitment Poster

LONDON metropolitan university

Research Study

BINGE EATING DISORDER AND MEN

The purpose of this research is to explore the experiences of men with Binge Eating Disorder

I would like to hear from you if:

- You are male
- You are 18 years old and older
- You are fluent in English
- You have a diagnosis of binge eating disorder from a health professional
- You are currently in treatment for binge eating disorder for at least one year (e. g. individual or group cognitive behavioral therapy, psychotherapy, interpersonal therapy, dialectical behavioural therapy, self-help).

What would participating in this research involve:

- An interview about your experiences of having binge eating disorder.
- The interview would last approximately 45-60 minutes

My name is Spyroula Spyrou. I am a trainee counselling psychologist at London Metropolitan University and this study is part of the Doctoral qualification in Counselling Psychology. If you are interested in participating or you have any questions please contact me at binge_eating_research@hotmail.com or [redacted].

You will be reimbursed for your participation with a £10 Amazon voucher.

Thank you for taking time to read this poster

Appendix B: Information sheet for participants

INFORMATION SHEET FOR PARTICIPANTS

You will be given a copy of this information sheet

Binge Eating Disorder: Understanding the experiences of men with BED

You have been invited to take part in this research study which aims to explore how men with Binge Eating Disorder (BED) experience and understand their eating disorder. Before you decide whether or not you would like to participate, it is important that you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and ask me if there is anything that is not clear or if you would like more information.

The researcher

My name is Spyroula Spyrou. I am a trainee counselling psychologist and I am carrying out this study as part of a Professional Doctorate Course in Counselling Psychology. The research is being supervised by Dr Mark Donati.

What is the purpose of the study?

The purpose of this study is to explore how men with BED experience and understand their eating disorder. Although existing research suggests that BED is equally common in both women and men; the vast majority of research studies on BED have been conducted on women. No known research study has been conducted on the experiences of men with BED. Given the high prevalence of BED in men it seems important to understand how men experience BED. It is hoped that this research study will increase the knowledge and understanding of people who work professionally to help men with BED (e.g. counselling psychologists). In addition it is also hoped that this study will provide men with BED with a voice to express their experiences of having BED.

Do I have to take part?

It is completely up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form agreeing to take part in the study. A decision not to take part or to withdraw at any time will not affect any treatment you are receiving in any way. If you decide to take part you are still free to withdraw from the study after the completion of the interview and all of your data will be erased. This can be done up until two weeks following the interview.

What is involved in participating in this study?

If you are interested in taking part in this study you can contact the researcher Spyroula Spyrou using the details below to make an appointment to meet on a day and a time that suits your schedule. The meeting can take place London Metropolitan University or at a location of your preference. The meeting will involve an interview where you will be able to talk about your experiences and understating of BED. During the meeting you will be given a consent form to sign and the interview will be carried out. It is anticipated that the interview will take approximately 45-60 minutes and it will be audio-recorded. Please note that you will be asked questions about your age, sexuality, occupation, marital status, BED and treatment, as this will allow the research to consider whether such factors are relevant to understanding eating disorders in men. You are free to share only as much information as you wish. The information you give will be kept confidential.

Confidentiality

This study is for research purposes only and the intended outcome for this research is that it will be used for a doctoral dissertation and possible journal publications. All the information obtained will be kept strictly confidential.

No identifying information will be revealed in any way in the doctoral thesis or publication of research. A pseudonym will be assigned to you and this will appear on all data. All of the information collected during the study, excluding your name, will be stored and analysed confidentially in a computer and secured under lock and key. No identifiers on the data held will enable a third party to link the data to you. The information will be kept for five years and then it will be erased. The results of this study may be published, however; no personal details will be revealed. A report of the findings of the research will be available to all interested participants on request.

However, there are limits to confidentiality. For example, if you disclose any information which suggests that either you, or someone else, is at risk of harm then I am obliged to breach confidentiality. In this case appropriate services or authorities will need to be informed. I will do my best to discuss this with you first.

What are the potential disadvantages of taking part in this study?

As part of the interview you will be asked to discuss your experiences and understanding of BED in some detail. This might cause you to feel distressed and measures will be taken to minimise the risk of distress. You may take a break or stop the interview if you feel upset or distressed. You have the right not to answer any questions if you do not wish to. This is to ensure that your well-being is safeguarded during the interview. After the interview, you will be able to ask

any questions or discuss any issues you would like. In addition, contact details for further support will be made available if you feel you need further support.

What are the potential benefits of taking part in this study?

It is hoped that this work will contribute to the understanding of BED by counselling psychologists and other practitioners and contribute to the improvement of treatment interventions for men with BED. You might also appreciate the opportunity to talk openly about your experiences.

Comments or concerns during the study

If you have a concern about any aspect of this study, you can contact me and I will do my best to answer your questions. Alternative you can contact my research supervisor, Dr Mark Donati through London Metropolitan University, (m.donati@londonmet.ac.uk; [redacted] .

If you would like some further information or you have any questions regarding this study please contact:

Spyroula Spyrou
Trainee Counselling Psychologist
E-mail: binge_eating_research@hotmail.com
Contact number: [redacted]

Thank you for taking the time to read this information sheet

Appendix C: Interview Schedule

Interview Schedule

Can you please state your age, sexuality, occupation and marital situation?

- How would you describe your eating problems?

- You have received a diagnosis of 'binge eating disorder'. What is your understanding of what this 'diagnosis' means?

- What is it like to have this diagnosis (Prompt: How do you feel about it? Do you find it helpful or unhelpful?)

- I wonder if you could talk me through a typical binge episode and what this is like for you. (Prompts: what happens? How does it start and end? What triggers it? What thoughts/feelings do you might have before, during or after the episode? Any images/words come to mind?)

- I am also interested in your understanding of why you engage in such eating behaviours. I wonder whether you could tell me why do you think you binge eat?

- Do you think being a man has affected your experience of these difficulties in any way? (Prompt: (if relevant) can you tell me what it is like to be a man with these difficulties?)

- (If relevant, in addition to be a man with these difficulties, do you think your sexuality as a gay/straight/bisexual man has any relevance in how you experience your eating difficulties?). (If relevant, can you tell me more about what it is like to be a gay/straight/bisexual man with eating difficulties?)

- Can you tell me what your experience of treatment has been like? (Prompt: is there anything that has been particularly helpful or unhelpful, or could have been better for you?)

- Is there any way in which you think services or treatments for men (gay/straight, etc if the participant felt this was relevant, as above) with 'binge eating disorder' could be improved or developed?

- Is there anything else that you think is relevant to this research topic I haven't asked you about?

- What has been like to do this interview with me?

Appendix D: Consent Form

Consent Form

Research study: Binge Eating Disorder: Understanding the experiences of men with BED

Researcher: Spyroula Spyrou

Please read the following statements and initial box

1. I confirm that I have read and understood the information sheet for the above study. I confirm that I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from the study until two weeks following the interview without giving any reason. ☐

3. I understand that the information I provide will be kept strictly confidential. There are limits to confidentiality where the researcher has to break confidentiality, for example if I disclose any information about harming others or myself. ☐

4. I give consent to the audio-taping and transcription of the interview, and to the use of direct quotes in the write-up of the study (which I understand will remain entirely confidential). ☐

5. I understand that the study is designed so that it will not cause me any harm or discomfort. However, due to the sensitive nature of some content of the interview, I understand that there might potentially be some distress. ☐

6. I understand that the purpose of this study is research and not therapy and any benefits from taking part in this study are welcomed but unintended. ☐

7. I agree to take part in the above study. ☐

Thank you!

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

Appendix E: Debriefing Information Sheet

DEBRIEFING INFORMATION SHEET

Binge Eating Disorder: understanding the experiences of men with BED

Thank you very much for making this study possible.

This study aimed to explore how men with Binge Eating Disorder (BED) experience and understand their eating disorder. I was interested in how you experience your binge eating and what it is like for you to receive a diagnosis of Binge Eating Disorder. I was also interested in your understanding of BED and how do you feel about having this eating disorder. It was also of interest to explore your experiences with seeking, accessing and receiving treatment for BED.

Although existing research suggests that BED is fairly common in both women and men the vast majority of research studies on BED are conducted on women as stereotypically eating disorders are considered to be female problems. There has been no known research conducted on the experiences of men with BED. Researchers have argued that further research into understanding the experiences of men with BED may be helpful in providing better treatment for men with BED.

The purpose of this study is research and not therapy, as this study is carried out as part of a Professional Doctorate Course in Counselling Psychology and any benefits from taking part in this study are welcomed but unintended.

Sources of support and help

If your participation in this study has raised any concerns or caused you any distress that you wish to discuss further, a number of sources of support which can provide you with advice and comfort in confidence are available.

- beating eating disorders (beat) is a leading UK charity for people with eating disorders and their families. Beatis the working name of the Eating Disorders Association which has been providing information, help and support for 20 years. The helpline is open from 10.30am to 8.30pm Monday to Friday, 1pm to 4.30pm on Sat, closed on Sun and open 11.30am to 2.30pmon Bank Holidays. Helpline number: 08456341414; www.b-eat.co.uk; help@b-eat.co.uk

- The Samaritans is a 24 hours helpline providing support to people in distress.
  Helpline number: 08457909090; www.samaritans.org

- Men Get Eating Disorders Too (MGECT) is a UK based charity dedicated to representing the needs and supporting the needs of men with eating disorders. Their website provides essential information to the

unique needs of men and offer peer support through their forum and chat room; www.mengetedstoo.co.uk

- British Psychological Society (BPS) is the representative body for psychology and psychologists in the UK. You can find contact details for accredited psychologists on the BPS website if you wish to; www.bps.org.uk

- British Association for Counselling and Psychotherapy (BACP) can provide information about how counselling can benefit an individual and how to access therapy and find a therapist. BACP can also provide advice on a range of services to help meet the needs of anyone seeking information about counselling and psychotherapy; www.bacp.co.uk

If you are interested in the results of the study, or if you have any questions about this study, or if you wish to withdraw, please contact the researcher on the following email address: binge_eating_research@hotmail.com. Please remember that if you wish to withdraw it should be done within two weeks of the interview date as it may not be possible at a later stage. A summary of the findings of the research will be available to all interested participants on request.

If you have any complaints regarding any aspect of the way you have been treated during the course of the study please contact the lead research supervisor; Dr Mark Donati on: [redacted] or email: [redacted]

Your contribution to this research study is very valuable and greatly appreciated.

Thank you very much for your participation

Appendix F: Distress Protocol

DISTRESS PROTOCOL

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their participation in the research study during their interview on the experience and understanding of Binge Eating Disorder (BED), as there is a possibility for participants to be suffering from BED and from some degree of other psychological difficulties.

The researcher is undergoing professional training in Counselling Psychology and has experience in managing situations where distress occurs. It is not expected that extreme distress will occur, nor that the relevant action will become necessary.

This is because full attempt will be made at the initial stages of recruitment to ensure that potential participants are not in an acute and vulnerable psychological state and assess their readiness to talk about their experiences of BED. This will be verified upon initial conduct with potential participants in order to minimise any risks.

In the case where participants become distressed and/or agitated a three step protocol is available, providing details for signs of distress that the researcher will look out for, as well as action to take at each stage.

Mild distress:

Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless
4) Pace of speech becomes slower and tone of speech becomes lower

Action to take:

1) Express concern and ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed
4) Determine if the person is experiencing emotional distress beyond what would be normally expected in an interview about a sensitive topic area

Severe distress:

Signs to look out for:

1) Uncontrolled crying/ wailing, incoherent speech
2) Panic/anxiety attack e.g. hyperventilation, shaking, fear of impending heart attack
3) Indications of flashbacks

4) Participant becomes extremely distracted/fidgety/breaking eye contact
5) Participant demonstrating extreme difficulties with concentration/attention owing to above

Action to take:

1) The researcher will intervene to terminate the interview
2) The debrief will begin immediately
3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
4) Assess mental status and ask participant what are they feeling right now and what thoughts are they having
5) The researcher will recognise participants' distress, and reassure that their experiences are normal reactions to expressing personal experiences on binge eating.
6) Ask the participant if they would like to speak to a friend or a member of family (e.g. over the phone) to help reassure them
7) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss this further with mental health professionals and remind participants that this is not designed as a therapeutic interaction
8) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

1) Severe emotional distress such as uncontrolled crying/wailing
2) Severe agitation and possible verbal or physical aggression
3) In very extreme cases suicidal ideation and plans expressed/possible psychotic breakdown

Action to take:

1) Maintain safety of participant and researcher
2) If the researcher has concerns for the participant's or others' safety, she will inform them that she has a duty to inform the appropriate mental health services such as their GP.
3) If the researcher believes that either the participant or someone else is in immediate danger, then she will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain them and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency).

Appendix G: Ethics Certificate

LONDON metropolitan university

London Metropolitan University,
School of Psychology,
Research Ethics Review Panel

I can confirm that the following project has received ethical approval to proceed:

Title: *Binge Eating Disorder: Understanding the experiences of men with BED*

Student: *Spyroula Spyrou*
Supervisor: *Dr Mark Donati*

Ethical approval to proceed has been granted providing that the study follows the ethical guidelines used by the Psychology Department and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel.

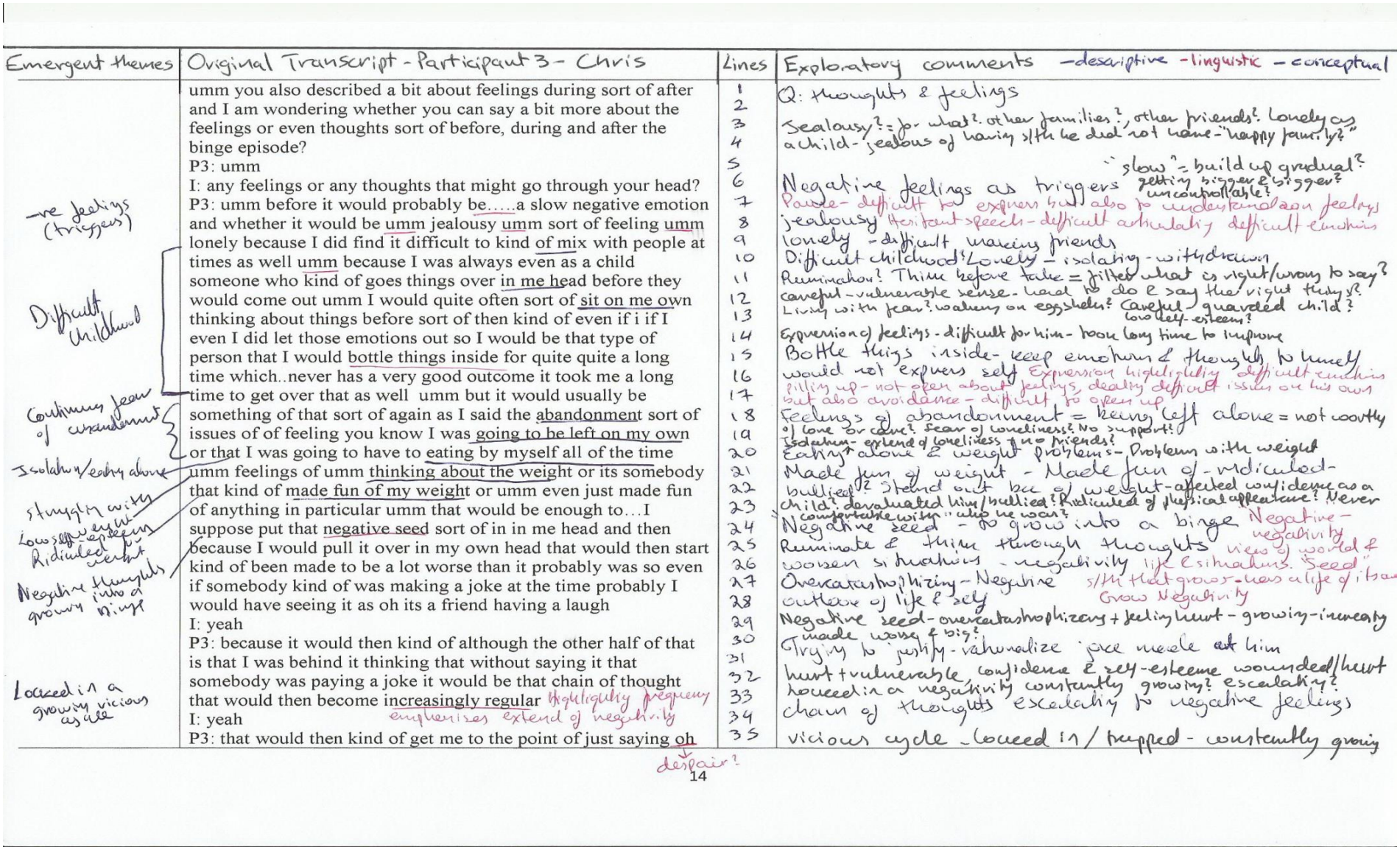
The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed:

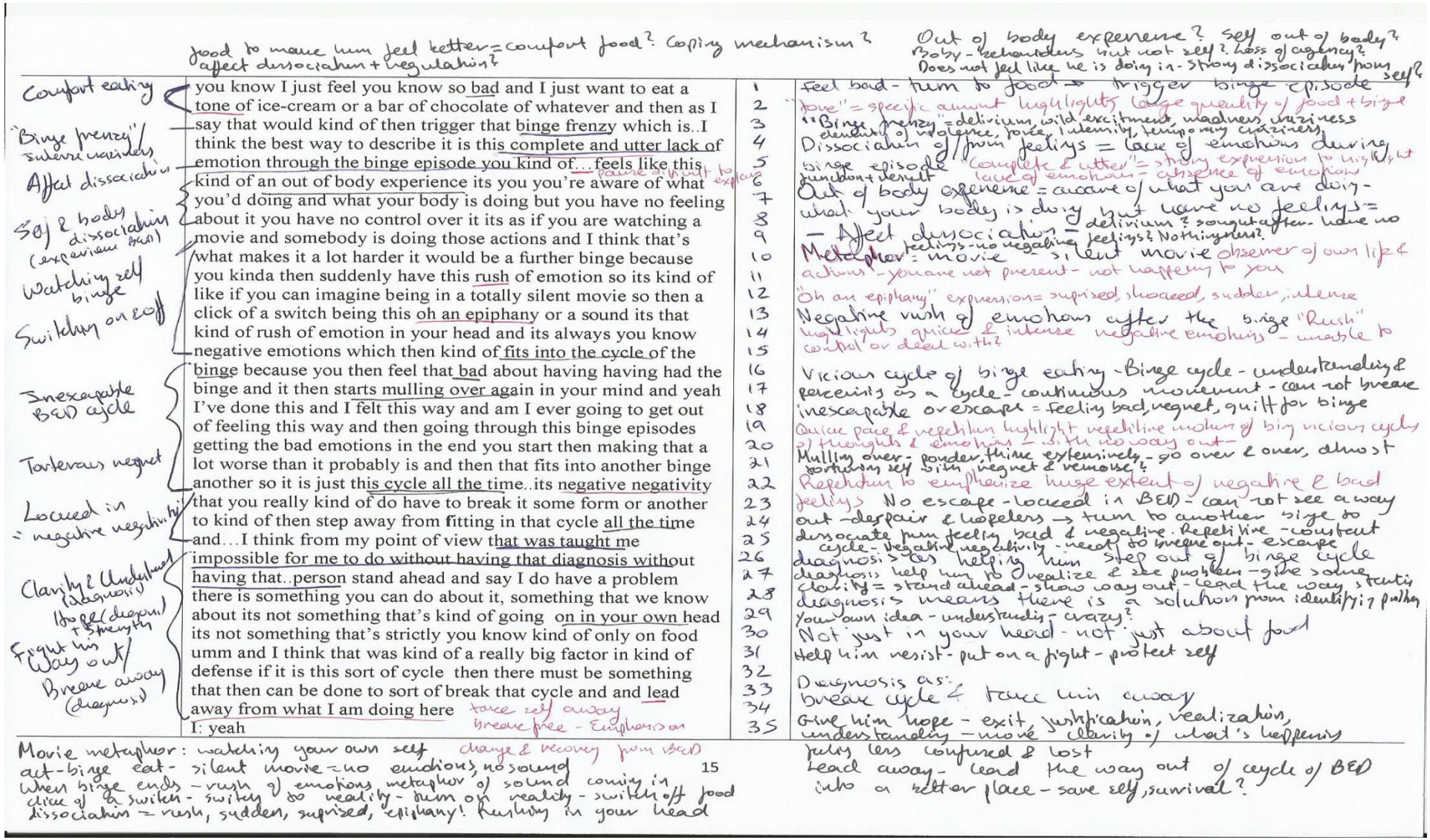
Date: 22/11/2011

Dr Chris Chandler
(Chair Psychology Research Ethics Review Panel)
[redacted]

Appendix H: Participant (Chris) interview transcript example



Emergent themes	Original Transcript - Participant 3 - Chris	Lines	Exploratory comments –descriptive –linguistic –conceptual
	umm you also described a bit about feelings during sort of after and I am wondering whether you can say a bit more about the feelings or even thoughts sort of before, during and after the binge episode?	1 2 3 4	Q: thoughts & feelings Jealousy? = for what? other families? other friends? lonely as a child - jealous of having s/th he did not have - "happy family?"
	P3: umm	5	"slow" = build up gradual?
-ve feelings (triggers)	I: any feelings or any thoughts that might go through your head? P3: umm before it would probably be…..a slow negative emotion and whether it would be umm jealousy umm sort of feeling umm	6 7 8	Negative feelings as triggers getting bigger & bigger? uncontrollable? Pause - difficult for express but also to understand own feelings jealousy Hesitant speech - difficult articulating difficult emotions
Difficult childhood	lonely because I did find it difficult to kind of mix with people at times as well umm because I was always even as a child someone who kind of goes things over in me head before they would come out umm I would quite often sort of sit on me own thinking about things before sort of then kind of even if i if I even I did let those emotions out so I would be that type of person that I would bottle things inside for quite quite a long time which..never has a very good outcome it took me a long	9 10 11 12 13 14 15 16	lonely - difficult making friends Difficult childhood? Lonely – isolating - withdrawn Rumination? Think before take = filter what is right/wrong to say? careful - vulnerable sense - hard to do & say the right things? Living with fear? walking on eggshells? Careful - guarded child? low self-esteem? Expressing feelings - difficult for him - took long time to improve Bottle things inside - keep emotions & thoughts to himself
Continuing fear of abandonment	time to get over that as well umm but it would usually be something of that sort of again as I said the abandonment sort of issues of of feeling you know I was going to be left on my own	17 18 19	would not express self Expression highlighting difficult emotions filling up - not open about feelings, deeply difficult issues on his own but also avoidance - difficult to open up Feelings of abandonment = being left alone = not worthy
Isolation/being alone	or that I was going to have to eating by myself all of the time	20	of love or care? fear of loneliness? No support? Isolation - extend of loneliness & no friends? Eating alone & weight problems - Problems with weight
Struggle with weight	umm feelings of umm thinking about the weight or its somebody that kind of made fun of my weight or umm even just made fun of anything in particular umm that would be enough to…I	21 22 23	Made fun of weight - Made fun of - ridiculed - bullied? Stand out bc of weight - affected confidence as a child? devaluated him/bullied? Ridiculed of physical appearance? Never comfortable with "who he was"?
Low self-esteem Ridiculed by others	suppose put that negative seed sort of in in me head and then	24	Negative seed - to grow into a binge Negative - negativity
Negative thoughts into a growing thing	because I would pull it over in my own head that would then start kind of been made to be a lot worse than it probably was so even if somebody kind of was making a joke at the time probably I would have seeing it as oh its a friend having a laugh	25 26 27 28	Ruminate & think through thoughts views of world & worsen situations - negativity like Esimations "seed" Overcatastrophizing - Negative s/th that grows - has a life of its own outlook of life & self Grow Negativity
Locked in a growing vicious circle	I: yeah P3: because it would then kind of although the other half of that is that I was behind it thinking that without saying it that somebody was paying a joke it would be that chain of thought that would then become increasingly regular highlighting frequency emphasises extend of negativity I: yeah P3: that would then kind of get me to the point of just saying oh	29 30 31 32 33 34 35	Negative seed - overcatastrophizing + feeling hurt - growing - increasing made worse & big? Trying to justify - rationalize give needle at him hurt + vulnerable, confidence & self-esteem wounded/hurt locked in a negativity constantly growing? escalating? chain of thoughts escalating to negative feelings vicious cycle - locked in / trapped - constantly growing despair?

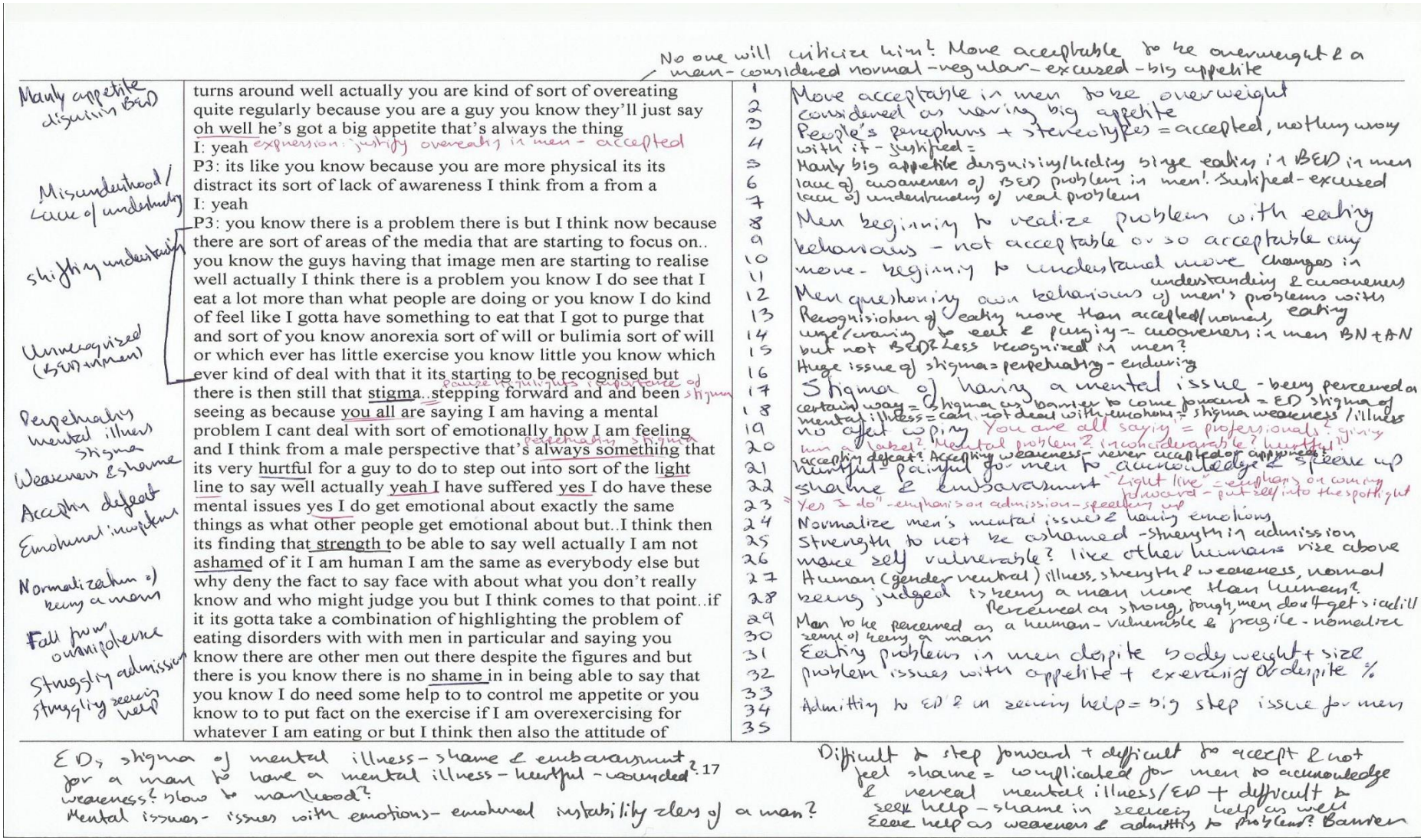

food to make him feel better = comfort food? coping mechanism?
affect dissociation + regulation?
Out of body experience? self out of body?
Body - mechanisms but not self? loss of agency?
Does not feel like he is doing it - strong dissociation from self?
Comfort eating
"Binge frenzy"/ extreme craziness
Affect dissociation
SOJ & body dissociation (experience itself)
Watching self binge
Switching on & off
Inescapable BED cycle
Torturous regret
Locked in = negative negativity
Clarity & Understood (diagnosis)
Hope (diagnosis) + strength
Fight his way out/ Breave away (diagnosis)
you know I just feel you know so bad and I just want to eat a
tone of ice-cream or a bar of chocolate of whatever and then as I
say that would kind of then trigger that binge frenzy which is..I
think the best way to describe it is this complete and utter lack of
emotion through the binge episode you kind of... feels like this
kind of an out of body experience its you you're aware of what
you'd doing and what your body is doing but you have no feeling
about it you have no control over it its as if you are watching a
movie and somebody is doing those actions and I think that's
what makes it a lot harder it would be a further binge because
you kinda then suddenly have this rush of emotion so its kind of
like if you can imagine being in a totally silent movie so then a
click of a switch being this oh an epiphany or a sound its that
kind of rush of emotion in your head and its always you know
negative emotions which then kind of fits into the cycle of the
binge because you then feel that bad about having having had the
binge and it then starts mulling over again in your mind and yeah
I've done this and I felt this way and am I ever going to get out
of feeling this way and then going through this binge episodes
getting the bad emotions in the end you start then making that a
lot worse than it probably is and then that fits into another binge
another so it is just this cycle all the time..its negative negativity
that you really kind of do have to break it some form or another
to kind of then step away from fitting in that cycle all the time
and...I think from my point of view that was taught me
impossible for me to do without having that diagnosis without
having that..person stand ahead and say I do have a problem
there is something you can do about it, something that we know
about its not something that's kind of going on in your own head
its not something that's strictly you know kind of only on food
umm and I think that was kind of a really big factor in kind of
defense if it is this sort of cycle then there must be something
that then can be done to sort of break that cycle and and lead
away from what I am doing here
I: yeah
pause & unsure how to explain
force self away
breave free - Emphasis on
1 feel bad - turn to food → trigger binge episode
2 "love" = specific amount highlights large quantity of food + binge
3 "Binge frenzy" = delirium, wild excitment, madness, craziness
4 elements of violence, force, intensity, temporary craziness
Dissociation of/from feelings = lack of emotions during
5 binge episode "complete & utter" = strong expression to highlight
6 junction + height lack of emotion - absence of emotion
Out of body experience = aware of what you are doing -
7 what your body is doing but have no feelings =
8 — Affect dissociation = delirium? sought after - have no
9 feelings - no negative feelings? Nothingness?
Metaphor = movie - silent movie observer of own life &
10 actions - you are not present - not happening to you
11
12 "Oh an epiphany" expression = suprised, shocked, sudden, intense
13 Negative rush of emotions after the binge "Rush"
14 highlights quick & intense negative emotions - unable to
15 control or deal with?
16 Vicious cycle of binge eating - Binge cycle - understanding &
17 perceiving as a cycle - continuous movement - can not breave
18 inescapable or escape = feeling bad, regret, guilt for binge
19 Quick pace & repetition highlight repetitive motion of big vicious cycle
20 of thoughts & emotions - with no way out -
21 Mulling over - ponder, think extensively - go over & over, almost
torturing self with regret & remorse?
22 Repetition to emphasize huge extent of negative & bad
23 feelings No escape - locked in BED - can not see a way
24 out - despair & hopeless → turn to another binge to
25 dissociate from feeling bad & negative. Repetitive - constant
26 cycle - Negative negativity - need to breave out - escape
diagnosis sees helping him step out of binge cycle
27 diagnosis help him to realize & see problem - give solution
28 clarity = stand ahead - show way out - lead the way, strength
diagnosis means there is a solution from identifying problem
29 your own idea - understanding - crazy?
30 Not just in your head - not just about food
31 Help him resist - put on a fight - protect self
32
33 Diagnosis as:
breave cycle & force him away
34
35 Give him hope - exit, justification, realization,
understanding - move clarity of what's happening
Movie metaphor: watching your own self change & recovery from BED
act - binge eat - silent movie - no emotions, no sound
When binge ends - rush of emotions, metaphor of sound coming in
click of a switch - switch to reality - turn on reality - switch off food
dissociation = rush, sudden, suprised, epiphany! Rushing in your head
15
Jolly less confused & lost
Lead away - lead the way out of cycle of BED
into a better place - save self, survival?

Two reactions to binge eating disorder diagnosis
Dual effect of diagnosis - two sides of the diagnosis
of understanding & impacting self = negative & positive

			Initial reaction to diagnosis - Subsequent reaction
Dual diagnosis effect	P3: umm I think the only thing that I did find really difficult after having the diagnosis and having those feelings was from a male perspective kind of having that support then you kind of do see a lot of umm female side of things so..all of the literature that I was able to find on eating disorders and things like that was always worded towards women towards a female perspective and I think because of the female body image being so prevalent in magazines media and everything around you it was kind of all focused on those sort of things whereas from a male perspective it was like still then taking up one step backwards towards that cycle and because you start thinking actually there are other people out there who have gone through this but not a lot of them seems to be guys or there isn't a lot of guys who are standing up and saying you know this is	1	Diagnosis as a man
		2	Difficult diagnosis - more focus on women not men
		3	Clear articulation - clear understanding of how diagnosis is affect him as a "man" - less focused
		4	
EDs female focus		5	Gender specific literature - focus on women
		6	Eating disorders - presented as female problem which is difficult for men - demoralizing for men??
		7	Focus on women + female body image - media focus
		8	Literature, media, information focusing on women = step back into BED cycle = loss of hope, difficulty to overcome this focus on women, demoralizing, another obstacle to overcome?
Demoralizing barrier		9	
		10	
Loneliness/ Isolation		11	Lack of men coming forward - standing up -
Secrecy + Stigma (not standing up)		12	admitting to BED = more women with BED (?)
		13	Lonely for men with ED/BED - men reluctant to come
		14	forward - stand their ground - emphasis on secrecy &
		15	stigma?
Socially acceptable behavior (ED)	I: yeah Men not stepping forward = accepted behavior - difficult to P3: but I also think that that would stem from I think in in societies point view if a guy overeats its not particularly seen as been an abnormal thing because the guy always eats the bigger portions you know always eats this and always eats and I mean it still makes me laugh today umm where if my wife lets say orders a steak when we are out and I'll order a salad they will always put the steak infront of me and the salad infront of her and it just kind of reinforces that that thing we were saying well actually there is just this subconscious thing who pretty much everywhere	16	Societal view - stereotype Strong male stereotype with food
		17	Guys can overeat - eat large portions = normal
		18	more accepted constant eating, big portion = normal & accepted
		19	Word choice "abnormal" = normal to overeat - always emphasis
		20	Strong - example of stereotype extent of this belief - stereotype
		21	gender stereotypes reinforced - widely believed = impact on
		22	female = salad steak = man BED? makes it more acceptable
		23	for men to binge eat? more difficult to recognize though?
		24	stereotype reinforcement = women eat lightly whereas
		25	men eat more - bigger portions
Recognition barrier		26	
		27	Media emphasis on women with BED/ED
		28	Huge emphasis on women & ED/BED - widely believed
		29	focus on ED & women - how it affects women only -
		30	men ignored - left out?
Gender eating behavior stereotypes		31	Men focus - perfect six abs - Perfect guy - physical perfection
		32	how a perfect man looks like - personification of an
		33	ideal man - perfect depiction of unattainable standards
		34	
Media disregards male EDs		35	
	I: hmm mm P3: but I think again that's that's because the media kind of always highlights the…female side of things and it it is kind of it seems to always to be more about how this disorder affects women as well I think kind of I'm starting to see a lot more now umm with guys magazines where there is that perfect guys in each now where you know with six abs I: yeah P3: and everything like that I think that is probably why I think only now starting to realise that there is a problem because I say for me it doesn't seem to be any kind of problem because nobody		
male physical perfection			

facing up - admitting
toward action

widely believed stereotype


No one will criticize him! More acceptable to be overweight & a man - considered normal - regular - excused - big appetite
Manly appetite disguising BED
Misunderstood / Lack of understanding
shifting understanding
Unrecognized (BED + women)
Perpetuating mental illness stigma
Weakness & shame
Accepting defeat
Emotional incapable
Normalization of being a man
Fall from omnipotence
Struggle admission struggle seeking help
turns around well actually you are kind of sort of overeating quite regularly because you are a guy you know they'll just say oh well he's got a big appetite that's always the thing
I: yeah expression: justify overeating in men - accepted
P3: its like you know because you are more physical its its distract its sort of lack of awareness I think from a from a
I: yeah
P3: you know there is a problem there is but I think now because there are sort of areas of the media that are starting to focus on.. you know the guys having that image men are starting to realise well actually I think there is a problem you know I do see that I eat a lot more than what people are doing or you know I do kind of feel like I gotta have something to eat that I got to purge that and sort of you know anorexia sort of will or bulimia sort of will or which ever has little exercise you know little you know which ever kind of deal with that it its starting to be recognised but there is then still that stigma..stepping forward and and been seeing as because you all are saying I am having a mental problem I cant deal with sort of emotionally how I am feeling and I think from a male perspective that's always something that its very hurtful for a guy to do to step out into sort of the light line to say well actually yeah I have suffered yes I do have these mental issues yes I do get emotional about exactly the same things as what other people get emotional about but..I think then its finding that strength to be able to say well actually I am not ashamed of it I am human I am the same as everybody else but why deny the fact to say face with about what you don't really know and who might judge you but I think comes to that point..if it its gotta take a combination of highlighting the problem of eating disorders with with men in particular and saying you know there are other men out there despite the figures and but there is you know there is no shame in in being able to say that you know I do need some help to to control me appetite or you know to to put fact on the exercise if I am overexercising for whatever I am eating or but I think then also the attitude of
pause in sniffles / importance of stigma
perpetuating stigma
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35
More acceptable in men to be overweight
considered as having big appetite
People's perceptions + stereotypes = accepted, nothing wrong with it - justified =
Manly big appetite disguising/hiding binge eating in BED in men
lack of awareness of BED problem in men! Justified - excused
lack of understanding of real problem
Men beginning to realize problem with eating behaviours - not acceptable or so acceptable any more - beginning to understand more changes in understanding & awareness
Men questioning own behaviours of men's problems with
Recognisation of eating more than accepted/normal, eating
use/craving to eat & purging - awareness in men BN + AN
but not BED? Less recognized in men?
Huge issue of stigma = perpetuating - enduring
Stigma of having a mental issue - being perceived in certain way = Stigma as barrier to come forward = ED stigma of mental illness = can not deal with emotions = stigma weakness / illness
no effect coping You are all saying = professionals giving him a label? Mental problem? incomprehensible? hurtful?
accepting defeat? Accepting weakness - never accepted or approved
hurtful painful for men to acknowledge & speak up
shame & embarrassment "Light live" = emphasis on coming forward - put self into the spotlight
"Yes I do" - emphasis on admission - speaking up
Normalize men's mental issues & having emotions
Strength to not be ashamed - strength in admission
make self vulnerable? like other humans rise above
Human (gender neutral) illness, strength & weakness, normal
being judged is being a man more than human?
Perceived as strong, tough, men don't get sick/ill
Men to be perceived as a human - vulnerable & fragile - normalize
sense of being a man
Eating problems in men despite body weight + size
problem issues with appetite + exercising or despite %
Admitting to ED & in seeking help = big step issue for men
ED, stigma of mental illness - shame & embarrassment
for a man to have a mental illness - hurtful - wounded? 17
weakness? blow to manhood?
Mental issues - issues with emotions - emotional instability signs of a man?
Difficult & step forward + difficult to accept & not feel shame = complicated for men to acknowledge & reveal mental illness/ED + difficult & seek help - shame in seeking help as well
Seek help as weakness & admitting to problems? Barriers

Appendix I: Table of super-ordinate themes for Chris

***Super-ordinate theme*& constituent sub-themes**	**Page/Line Number**	**Quotation references**
Futile diagnosis: finding and losing hope in recovery		
Positive realisation	5/5-6	'a reason behind some of the weight gain'
Explanation and solution	5/5-6; 5/9-11; 5/23-26	'it was a realisation that..there was a reason behind some of the weight gain'; 'but there is a problem behind it'; 'gave me a bit more strength … how do I eventually get back to being that sort of normal eating pattern'
Relief	5/31-33	'I think relief..yeah because I've gone for so many years struggling with weight'
Clarity and understanding	15/25-30	'taught me impossible for me to do without having that diagnosis…it's not something that's kind of going on in your own head it's not something that's strictly you know kind of only on food'
Hope and strength	15/25-34	'there must be something that then can be done to sort of break that cycle'
Fight way out/Break away	15/31-34	'break that cycle and and lead away from what I am doing here'
Dual diagnosis effect	16/1-3	'I did find really difficult after having the diagnosis and having those feelings was from a male perspective kind of having that support'
Deficient diagnosis	20/5-7	'from the initial kind of diagnosis that I got I wasn't given a lot of information about binge eating disorder'
Futile diagnostic term	20/22-28	'I will be cured and eventually what happened…it became kind of well is it just something that they've got a term for that'
Loss of hope	20/17-18	'I think from not having the information kind of then did knock confidence in having a diagnosis'
Understanding behaviour/justifying behaviour	6/31-35	'something that was identifiable and that I could say yes it was because of this that I do do binge'
Helpless despair	20/25-35	'just something that they've got a term for that or..or I don't really know how to deal with'
Shocking discovery	1/19-21	'quite difficult to actually sort of take that on'
Early life experiences in developing dysfunctional eating		
Difficult childhood	14/9-15; 35/12-17	'bottle things inside'; 'being quite young and my parents split…he is no longer part of

		my life’
Paternal control over forced eating	2/1-13	‘father stepfather umm would always make you clean your plate from everything that was on it..feel the pressure to eat..have to do it rather than actually enjoying the food’
Developing problematic eating relationship with food	2/17-24	‘I would skip a meal at school’
Traumatic adolescence	2/34-35	‘divorce and that was that was quite of uuu I think a traumatic time’
Instability and uncertainty	3/1-5; 7/19-28	‘I suppose the actual pressure of that and not knowing when we would be living…something that was of a a a big shock’; ‘was the instability of the family life..the fear of being abandoned..that instability of not knowing’
Loss of family stability	3/1-8	‘not knowing when we would be living we had to move around different places ‘
Strict food rules obedience	3/11-12; 3/18-20	‘too strict with me’; ‘ sat at the table for 4 hours because she she didn’t like what she was suppose to be eating’
Food extortion	3/18-22	‘been made to sit and eat’
Understanding BED development	2/7-14	‘you have to do it rather than actually enjoying the food you know..so I think that’s kind of the start of it all where it came from’
Continuous fear of abandonment	7/19-22; 14/18-19	‘the instability of the family life emm…sort of abandonment not in being abandoned but the fear of being abandoned’; ‘I was going to be left on my own’
Unprotected and vulnerable self	7/28-29	‘whether tomorrow was going to be another day where you would be left to defend yourself’
Misunderstanding BED: Suffering without knowing		
Suffering without knowing	1/4-19	‘it being I’d probably say when I was 13-14 years..but at the time I didn’t actually it was any kind of problem until I was round about 22-23’
Misunderstood and unrecognised	1/5-8; 1/13-14	‘purely by chance’; ‘difficulties with the weight ‘
Lack of understanding	2/24-26	‘I didn’t realise it at the time’
Difficult to recognise	4/1-3	‘it was kind of the start of all’
Excessive eating misunderstanding	4/6-7	‘a lot quicker than what you should eat’
Perception of obesity/misunderstood BED	5/10-13; 5/18-20	‘eat a load whole of rubbish and the same as everybody else exercise that self control’; ‘people get big because they eat too much or they are eating the wrong kinds of food’
Misunderstood/Lack of understanding	17/1-3	‘he’s got a big appetite that’s always the thing’

Unrecognised	17/10-15	‘there is a problem you know I do see that I eat a lot more than what people are doing’
Living a constrained life		
Social impairment	1/26-32	‘realised that I didn’t actually sit down to have meals with other people..quite difficult’
Depression	6/13-20; 37/5-7	‘I used to spend months on end sitting in the house’; ‘its kind of me that’s gone through this’
Constrained life	6/13-20; 21/30-34; 29/28-32	‘I didn’t actually want to go out of the house; ‘I can take so many knocks but if I go one further that’s then going to set me even back’; ‘once you suffer from it..you will always be conscious of it being there’
Transformation	6/26-28	‘i ..felt repulsed for looking at myself and even I wasn’t satisfied with the way that I was’
Disabling impact	6/13-20	‘even umm even going to the doctor’s appointment was such a traumatic thing’
Isolation/Eating alone	1/26-32; 14/20	‘very difficult to kind of sit and eat anything’; ‘eating by myself all the time’
Satiety and hunger impairment	4/13-14	‘even to this day I don’t ever get hungry and I don’t ever feel satisfied’
Psychological consequences of binge eating		
Regret	6/8-9	‘I am not going to eat anything because if I do eat anything I’ve put all of this weight on’
Pain	4/22-23	‘pain sort of stomach pain, the nausea all of that kind of things’
Shocked	9/3	‘oh whoao I’ve just..eaten all of that food’
Negative feelings flood in	9/4-7	‘quickly feelings of guilt, feelings of shame that I’ve done it’
Torturous regret	15/16-19	‘starts mulling over again in your mind’
Suicidal ideation	22/19-22	‘it is eventually that dangerous to someone going through it that feeling that lack of support’
Failure and disappointment	4/24-27	‘I should have stopped you know’
Draining emotionally/Numb and emotionally distant	34/12-15	‘it then brings a demented that iiits your uuuu like a tone of bricks’
The benefits of male group therapy		
Group therapy	27/28	‘group therapy..would be beneficial’
Address isolation	27/28-31	‘beneficial to kind of address the fact of not being the not kind of having that..isolation’
Male peer support	27/29-31	‘being able to talk to males and guys who have gone through the whole process’
Inspirational recovery	27/29-33	‘guys who have gone through the whole

		process..and kind of come out the other side'
Dispense stigma	28/1-4	'the biggest recommendation because the isolation and the feelings of sort of stepping away from the general sort of population of other men'
Male specific treatment recommendations		
Support groups and online information	26/16-18	'no information about the support groups there was no umm even websites'
Support and empathy	25/27-29	'lack of support and empathy again from a male perspective… makes it very difficult'
Inspirational male role models	25/30-34	'it may take somebody whose actually gone through the experience'
Male celebrity	19/13-18	'what it takes its some celebrity to come out'
Inspirational role model	19/23-26	'I've gone through it in the past'
Family support	19/30	'support of you know family'
BED info to instil hope	20/25-28	'not have information to hand..it just something that they've got a term for that'
Gender differences in coping with BED	3/30-31	'go through the diets and stuff than I was would go through exercising and weights'
Experience of receiving treatment as inadequate and insufficient		
Lack of specific treatment	21/10-11	'the cognitive behavioural..I suppose generic'
Inadequate treatment	21/11-18	'it was more sort of we'll deal with negative feelings wasn't specifically about well why were these negative'
Sense of abandonment	21/17-21; 26/12-13' 29/15-21	'self awareness and capability of working through things in my own mind'; '12 weeks of CBT and then dropped'; 'just deal with it yourself '
Inadequate information and support	22/5-8	'there isn't as much support as much as you kind of need it or expected to be there'
Inadequate treatment and support	29/8-18	'it isn't something that it can be done over 12 weeks..how do I deal with them?'
Let down	29/10-14	'we'll touch on some of the things that could be causing it now we'll see you later'
Lack of sympathy and empathy	29/10-21	'there was nothing there to replace so it was so thank you very much see you later'
Resentment	29/17-21	' just being dropped you know just deal with it yourself'
Inadequate and insufficient treatment	26/8-13	'the treatments there is isn't quite where it should be.. no further communication no support from the GP nothing at all'
Inadequate BED information	20/6-10; 23/3-6	'I wasn't given a lot of information about binge eating disorder it's a I was given information about eating disorders'; ' whenever eating disorders are mentioned anorexia or bulimia are the first things that

		come up anywhere'
Loss of trust in professionals	20/20-28	'always put doctors upon this pedestal.. I've got binge eating disorder so now..I will be cured..not have information to hand about the specifics'
Loss of hope and confidence	21/25-27	'undermine that confidence again and and sort of set you back'
Overcoming barriers un-appreciation	26/5-9	'I need some support to do it its kind of making yourself even more vulnerable because you then set yourself aside from everybody'
Seeking help barrier: self-inflicted stigmatization		
Struggling admission	17/24-26	'its finding that strength to be able to say well actually I am not ashamed of it I am human'
Difficult admission	23/30-32	'from a male perspective..is a lot more difficult than it is for a women'
Breaking away from stereotype	23/26-32	'for a woman to be emotional that's kind of socially acceptable for a women'
Difficulty stepping forward	25/35-26/1	'the step that it takes to actually put yourself forward'
Stigmatize own self	26/1-2; 28/3-8; 28/16-19	'I am not like the rest'; 'traumatic in itself because you are singling yourself out'; 'have a diagnosis I have to step away from the stereotype'
Outcasting own self	26/5-6	'set yourself aside from everybody else'
Daunting and traumatic	28/6-8	'singling yourself out'
Being less of a man	28/7-12	'step away from the male forms'
Set back	28/16-21	'I could be a target for feelings and emotions that I could then set me back'
Intimidating exposure	28/6-20	'daunting and and you you know quite sort of I suppose traumatic in itself...stepping forward'
The 'macho male' man		
Macho male personification	18/1-4	'the macho kind of image'
Fitting in male stereotype	18/4-10	'fit into that whole macho kind of stereotype just to see like I was fitting in with everybody else'
Sense of omnipotence	19/1-2	'you don't have emotions you know you can't feel upset you can't feel upset'
Strong male personification	24/14-19	'a guy was the guy..you were the strong'
Male stereotype	24/3-6	'never see that happen to a guy'
Male physical perfection	16/30-31	'perfect guys..with six abs'
Normalize BED in men		
Normalize BED in men	18/12-18; 19/17-20;	'happens with human beings as whole'; 'it's going to take something high profile'; 'we

	28/21-26	know exactly what you are going through…such a big boost'
Common and accepted	18/14-18	'you are not the only one..it's not abnormal to sort of have these feelings '
Break stereotype of unbreakable/omnipotent man	18/12-18	'a break away with that that way of thinking with guys'
Change male stereotype	19/10-13; 24/20-23	'highlighted through the likes of research, through publicizing'; 'more men now who really are kind of being a little more accepting with seeing things'
Normalization of being a man	17/23-26; 17/29-33	'I am human I am the same as everybody else'; 'there are other men out there despite the figures'
Fall from omnipotence	17/25-26	'finding that strength to be able to say well actually I am not ashamed of it I am human'
Gender neutral	18/17-20	'it's not a..female thing it's not a male thing'
BED stigmatisation: rare disgraceful marginalization		
BED as emotional problems acceptable for women	23/26-28	'for a woman to be emotional that's kind of socially acceptable'
Female emotional coping stereotype	23/33-35	'eats a tap of ice cream that's normal'
Emotional stigma	24/8-9	'it's wrong to show all of those emotions'
Strong female association barrier	18/29-32	'they must have an eating disorder and this kind of..i think accepted..for them'
Emotional disorder	18/32-34	'she must have an eating disorder and it was well you know women are emotional'
Emotional stigma barrier	19/1-2	'you don't have emotions…you can't feel upset'
BED as emotional problems	27/19	'deal with the emotional side of it'
Perpetuating mental illness stigma	17/17-19	'still that stigma'
Weakness and stigma	17/17-23	'can't deal with sort of emotionally how I am feeling'
Accepting defeat	17/18-23	'always something that its very hurtful for a guy'
Emotional incompetence	17/19-24	'I have suffered yes I do have these mental issues yes I do get emotional'
Intense craziness		
Intense craziness	8/23-27; 10/9; 34/12-14	'frenzy…just blurred out from me self..so manic'; 'binge sort of frenzy epiphany'; 'it then brings a demented..tone of bricks'
'Binge frenzy'/Intense craziness	15/3-4	'trigger that binge frenzy'
Abnormal	23/17-18	'it's not a normal sort of situation for the average person to find themselves in'
Life disruption	27/34	'an upsetting period of time'
Traumatic experience	36/15	'traumatic thing that I don't want to go back to'
Unstoppable	9/1-2	'go on until that last bit of food has gone in'
Going crazy	7/35	'paranoia'

'Negative negativity': locked in a vicious cycle		
Endless suffering	1/3-8; 8/6-8	'I've probably all had them for well as long as I can remember'; 'the first binges that I can remember...would come home from school'
Continuous struggle	1/26-32; 4/14-18; 11/32-35; 26/23-25	'didn't actually sit down to have meals with other people'; 'I am still not quite finished'; 'humiliation kind of fitting into that cycle'; 'still even to this day I am still struggling'
Vicious cycle	11/33	'fitting into that cycle that's all I think you know'
Constant struggle	12/2-6	'distractions or my wife's kind of become an A factor in realizing sometimes even when I don't'
Locked in a growing vicious cycle	14/32-33	'it would be that chain of thought that would then become increasingly regular'
Inescapable BED cycle	15/15-22	'fits into the cycle of the binge..starts mulling over again in your mind…just this cycle all the time'
Locked in 'negative negativity' fear	15/22-24	'negative negativity..do have to break'
Inescapable trap	21/1-7	'knock your confidence even that little bit more and set you that one step back'
Struggling for recovery/survival	21/3-7; 22/1-4	'self doubt'; 'done it before and I am back on that happening again'
Difficult journey	21/27-29; 26/30-33; 36/3-5	'you always feel you've got to be very aware'; 'that fall can be really quite scary'; 'a continuation of…assessing…where I want to be'
Inescapable/Hopeless recovery	29/23-34	'I will never be cured of having Binge Eating Disorder its always something that is there at the back of my mind'
Running in circle	30/2-4	'I am back where I I was at the very beginning'
Fighting for escape	28/29-30	'breaking out of that cycle and breaking away'
Locked in vicious cycle/trapped	6/10-13; 22/1-4; 22/13-17	'get straight back on so for years and years'; 'more difficult to break out of'; 'the cycle of then been unwell is this ever going to end?'
Despair and disappointment	22/12-17	'is it something that's going to happen for the rest of my life? am I always going to feel so bad'
Hopeless despair	30/2-4	'all ok but I am back where I was at the very beginning'
'Compelling instinct': the loss of self-control		
Strive for control	4/14-18	'I can't remember the times that I not feel any sort of affected'
Loss of control over eating	4/18-20;	'eat another afterwards and another one after

	11/11-15	that and keep going keep going'; 'self control thing again..easy access easy to get a hold'
Failure to control eating	8/21-23	'once that first sort of step being made it quickly became I suppose a frenzy'
Intimidating loss of control	9/8-10	'I didn't have this self control to be able to stop'
Uncontrollable control/Oxymoron control	9/27-32	'the receipt was only something I was in control of'
Control struggle	12/13-14	'without sort of any degree of control of myself'
Struggling with self control	13/28-30	'been able to realise I am losing control'
Complete lack of self control	23/10-12	'lack of self control..the most important factor of having binge eating disorder'
Uncontrollable temptation	10/1-7	'this is here I know it's there'
Compelling instinct/Loss of self control	5/16; 5/27	'this instinct that takes over that….compels me to do it'; 'being compelled to eat'
Restrain self	23/12-13	'strap yourself back from the food'
Self under restrainment	10/25-28	'I have to be taken out of control of those'
In control	8/17-20	'eating pretty much everything that I bought'
In control of binge plan	9/24-32	'away from anybody that could see'
Surrender self to overpowering BED		
Power struggle	21/29-34	'I can take so many knocks but if I go one further that's then going to set me even back'
Surrender self to BED	6/5-6; 8/27-29	'not wanting to care not wanting to think about food'; 'something so manic that the food be placed without any thoughts or caring'
BED in control of self	9/7-10	'a bit of fear there as well that actually I didn't have this self control'
BED overpowering self	5/26-27; 10/25-27; 12/13-14	'being compelled to eat..the bad things'; 'I have to be taken out of control of those'; 'without sort of any degree of control of myself at all'
Uncontrollable subconscious	10/10; 29/23-27	'you are not in control of that subconscious'; 'its always something that is there at the back of my mind..I am aware could happen without me being aware of it and in control of it'
Overpowering BED	23/11-13; 29/23-27; 30/5	'the lack of been able to strap yourself back from the food'; 'I am aware could happen without me being aware of it and in control of it'; 'service or support there permanently'
Loss of self in BED	23/16-17	'no control you are not aware of what's going on'
Dual positive and negative consequences		

Secrecy and hiding	4/5-6; 8/4-5; 8/14-16; 11/8-9	'I had become so very good at hiding it'; 'on my own and or everybody would be asleep'; 'I knew I was going to have the house to myself'; 'its easy it to kind of disguise the fact that I had it'
Secrecy and hiding/Shame and fear	9/24-32	'everything that I bought there hadn't been bought by anybody else in the house'
Fear of being caught	11/16-20; 11/28-29	'somebody could then pack it at any time and witness that so and that kind of added to the speed'; 'being caught into that binge'
Inherently wrong behaviour	11/21-22	'something not quite right I suppose'
Shameful behaviour and consequences	11/28-32	'the reason why you've put on all of this weight is because of this..having that sort of humiliation'
Pretending to be normal	9/17-20	'keepup the appearances..as if nothing was out of the ordinary'
Large quantity and accessibility to forbidden food		
Excessive eating	4/3-4; 6/4-5; 8/9-13	'all of the stuff things going missing'; ' eating basically anything and everything'; 'talking about full binge umm twelve packs of crisps'
'Bad fatty food'/Forbidden food	8/10-11	'loads of really bad fatty food'
Convenient binge food/Easy and accessible	9/21-24; 10/33-35; 11/3; 11/11-15	'fairly easily cookable'; 'cheese would be kind of one of those things that was easy to access'; 'so quickly so quickly'; 'easy access easy to get a hold'
Evolving binge preferences	12/22-35	'open up so much more possibility and also developing an adult taste'
Expand binge eating	13/18-20	'on your own where you weren't supervised'
Fragile sense of improvement		
Sense of improvement	13/22-24	'I've got a lot more awareness of what goes on'
Fragile sense of improvement	21/30-34	'I can take so many knocks but if I go one further that's then going to set me even back'
Evolving coping strategies	12/11-14	'now it's kind of having those open strategies'
Distracting strategies/Preventing binge	12/2-4	'my wife's kind of become an A factor in realizing sometimes even when I don't that'
Gaining understanding	7/18-19; 7/27-29; 13/30-33	'came down to was the instability of the family'; 'that instability of not knowing'; 'leads to getting a lot out'
Sense of control and improvement	7/13-17	'distract myself from those kind of feelings'
Helpful treatment	19/30-33	'talking about it is the best way of getting it out'
Gaining strength	36/5-9	'cope with it in a way of not resorting to sort of ways in which I would do things'

Positive perspective shift	36/12-17	'if you chose it to it can strengthen how you feel'
Negative perception of self		
Low self esteem	14/21-23	'made fun of my weight..that would be enough'
Weak/fragile and vulnerable self	21/3-7; 28/28-30	'relatively minor would just knock your confidence..and set you that one step back'; 'not feeling so much like you could be knocked back into the cycle so very easily'
Failure and hopelessness	22/1-4; 26/25-33	'feeling that low and having those kind of the weight issues'; 'every day being difficult'
Unworthy of love and happiness	7/33-34	'self loathing'
Self aversion	6/26-28	'felt repulsed for looking at myself and even I wasn't satisfied with the way that I was'
Self as vulnerable and untrustworthy	10/24-28	'if even to this day if I eat those particular foods it can trigger a binge episode very very quickly'
Humiliating weight struggles signal BED problems		
Weight signalling BED problems	1/7-14; 4/10-13	'I always had problems with my weight'; 'I gained 3st in about 2motnhs'
Struggling to control weight fluctuations	5/31-33	'I've gone for so many years struggling with weight umm fat diets emm yo yo of the weight'
Ridiculed for weight	11/23-28; 14/21-23	'often get to be about my weight..but I wouldn't let it show'; 'made fun of my weight'
Criticised and humiliated	11/28-32	'being kind of open bothered and and having that sort of humiliation'
Struggling with weight	14/21-22	'thinking about the weight or its somebody that kind of made fun of my weight'
Instability (eating patterns/emotions/weight)	5/31-32; 6/1; 6/28-29	'yo yo of the weight'; 'patterns would change'; 'would go from very emm aggressive at points to very kind of quite'
Sense of isolation: helplessly struggling alone		
Seeking unavailable help/support	22/5-8; 30/4-12	'there isn't as much support as much as you kind of need it or expected to be there'; 'there should be some form of service or support there permanently'
Helplessly struggling alone/Isolation	22/4-8	'I am back on that happening again…the lack of support and the lack of information did I have I think a major played a major part'
Seeking understanding	21/12-15	'why were these negative feelings then that lead to the eating patterns'
Struggle alone	21/20-24;	'having that self awareness and capability of

	26/19-21	working through things in my own mind'; 'finding a way of adapting it to my situation'
Struggle to understand	20/6-10	'I wasn't given a lot of information about binge eating disorder it's a I was given information about eating disorders'
Struggling seeking help	17/31-33	'there is you know there is no shame in in being able to say that you know I do need some help'
In need of support and help	12/10-11; 26/35; 30/5-12	'she is realizing that I am struggling so then kind of supports through that way'; 'the support definitely needs to be there'; 'service or support there permanently..someone by standing just help steering me up'
Binge eating: food evolution in complicating men's' roles		
Complicated male roles	32/20-27	'evolutionary thing…hunt we get what we need'
Evolutionary food changes	32/30-35; 34/21-23	'food is so widely available..a big factor that contributes to the binge eating disorder'; 'evolution has come on being from a necessity..this big social part of it'
Complex lifestyle/Life as more complicated	32/33-35+33/1-3	'dietary changes..if that sort of lifestyle hadn't come about…wouldn't be availability of the food'
Excess availability	33/1-3	'wouldn't be an opportunity to have that binge episode..wouldn't be availability of the food'
Food addiction: craving unattainable happiness		
Food addiction	33/6	'binge eating as being a food addiction'
Emotional attachment	33/7-12	'having that emotional tie with food..close bond and emotional bond'
Nurturance	33/10-12	'going back to sort of being a infant'
Bonding family	33/13-17	'family meals sitting down the sociality of it and and associating that with the love of food'
Craving love and happiness	33/12-22	'haven't had that social tie with the family..then you crave it even more'
Addicted to finding happiness	33/25-27	'I haven't had that I need to have that and then that kind of then becomes the addiction'
Unattainable happiness	33/21-22	'bonding experience around food then you crave it even more'
Excessive focus	33/25-27	'becomes the addiction that keeps the focus onto'
Emotional hunger	33/29-31	'crave even more and crave it even more hungry'
Unattainable fake ideals	34/26-35	'everything that you see as being normal

		which is actually a skewed version of normal'
The dual consequences of binge eating		
Pleasure and satisfaction	8/18; 12/23-24; 13/1-5; 34/4	'eaten fried I liked that'; 'something that was pleasurable to eat'; 'so much more that I can you know factor in these binge episodes'; 'having a great time and enjoying the experience'
Comfort eating	15/1-2	'feel you know so bad and I just want to eat a tone of ice-cream'
Affect dissociation	15/4-5	'complete and utter lack of emotion through the binge episode'
Emotional coping mechanism/ comfort eating	12/1-2; 34/19-21	'get into an emotional state quite often I will think of food first'; 'isolation which makes you feel like you want that support and you turn to the food'
Emotional compensation	33/29-32; 35/24-25	'compensate from not having that sort of that support behind you'; 'trying to find that emotion'
Affect dissociation/Trade off	33/34-35+34/1-4	'eating the food kind of they don't make you feel better but you assume that's what's happening'
Reward self reassurance	34/1-4	'having a great time and enjoying the experience'
Two-sided BED	34/4-6	'it's the negative emotions that came back'
Failed expectations	34/5-9	'it's the negative emotions that came back and not the positive emotions'
Shocking reality	34/7-14	'get a big shock from it as well which it it it leads into the cycle..it's the realization of the..amount of the food that you've eaten and the type of food'
'Silent movie': experiencing dissociation from self		
Self and body dissociation	15/6-8	'an out of body experience..have no feeling about it you have no control over it'
Watching self binge	15/8-9	'as if you are watching a movie and somebody is doing those actions'
Switching on and off	15/11-15	'being in a totally silent movie so then a click of a switch..rush of emotion in your head and its always you know negative emotions'
Dissociate from own self	8/24-29; 8/32; 23/16-17	'just blurred out from myself'; 'I didn't realise what I was doing'; 'not aware of what's going on its not a normal sort of situation'
Aware of unawareness	29/26-27	'could happen without me being aware of it'
Lack of BED recognition and exposure		

Media disregarding male EDs	16/26-29	'more about how this disorder affects women'
Diminish severity of BED	23/18-21	'if it's just something not been seen as particularly big problem'
Lack of recognition and awareness (self and others)	18/21-25	'I've never heard of it..being a male thing it was well isn't women that have eating disorders'
Inadequate exposure	18/24-27	'I've never heard of it I've never seen it'
Sense of isolation and stigma	23/3-6	'whenever eating disorders are mentioned anorexia or bulimia are the first things that come up'
Seeking help barrier: self-inflicted stigmatization		
EDs female focus	16/4-6	'always worded towards women towards a female perspective'
Demoralizing barrier	16/9-11	'taking up one step backwards towards that cycle'
Loneliness/Isolation	16/12-13;34/18-21; 37/5-7	'not a lot of them seems to be guys or there isn't a lot of guys who are standing up'; 'I am not like other people or I am kind of in isolation'; 'there are people who are depressed'
Secrecy and stigma	16/12-13	'there isn't a lot of guys who are standing up'
Stigmatization of men with EDs: a rare disgraceful marginalisation		
Social 'segregational boxes'	31/20-24	'these little boxes that kind of people fit into'
Exemption (not fitting in)	31/20-22	'always going to be exemptions to those cases'
Outcast	31/28-29; 34/17-19	'the community in which they place themselves'; 'difficult to relate to people and to open up'
Others' perceptions	32/1-3	'how you perceive other people seeing you'
Closeted	24/24-27	'male celebrity has a break down goes away in secret'
Socially acceptable	24/28-30	'lot more sympathy as well with a female side of it because the emotions are accepted'
'Alien'	25/1-3; 25/21-22	'alien..not used at seeing it'; 'no way of empathizing of it because it's just so alien'
Stigmatised	25/1-3; 25/12-14	'how do I identify with that because we are so not used at seeing it'; 'this is something to be ridiculed'
Degrading	25/12-14	'laugh at because he's gone on this big rant'
Subject to ridicule	25/12-14; 28/10-14	'this is something to be ridiculed'; 'I know for a fact that there would be a bundle of jokes'
Not taken seriously	25/12-14; 25/21-24;	'you want to kind of laugh at' ; 'there is no sympathy'; 'lack of support and empathy'

	25/27-29	
Failing/Falling behind	21/7-9	'from a male perspective of it you always felt like playing catch up with everything else'
Disbelief	18/20-23	'isn't women that have eating disorders I didn't realise that it could happen to men''
Male stereotypes concealing BED		
Exercising disguising eating problems	2/27-30; 4/9-13	'I did exercise quite a lot and I was either playing a game or I was training'; 'not being able to do any exercise..gained 3st in about 2motnhs'
Socially acceptable behaviour	16/16-19	'the guy always eats the bigger portions you know always eats this and always eats'
Recognition barrier	16/13-18	'if a guy overeats its not particularly seen as been an abnormal thing'
Gender eating behaviour stereotype	16/20-24	'put the steak in front of me and the salad in front of her'
Manly appetite disguising BED	17/1-3	'he's got a big appetite that's always the thing'
Hopeless recovery: learning to live with BED		
Hopeless recovery	29/23-34	'I will never be cured of having Binge Eating Disorder its always something that is there at the back of my mind'
Living in fear	21/33-34; 26/30-33; 29/28-32	'take so many knocks but if I go one further that's then going to set me even back'; 'I am not 100% on top of my game..that fall can be really quite scary'; 'I always say that once you suffer from it..you will always be conscious of it being there'
Loss of hope and confidence	20/30-35	'only a few people that have gone through it..knock that confidence'
Loss of hope and trust	21/5-7	'set you that one step back'
Hoping for recovery	19/28-29	'it's not part of what's for me in the future'
Adapt life around BED	36/16-20	'back in that situation I know that I would be out of it through my own'
Multiple triggers heightening binge eating vulnerability		
Specific food triggers vulnerability	10/18-22	'there was certain umm foods as well that would feature very strongly in the binges'
Negative feelings	14/7-9	'a slow negative emotion and whether it would be umm jealousy umm sort of feeling umm lonely'
Negative thoughts growing into a binge	14/24-26	'been made to be a lot worse than it probably was'
One part of self not all of self		
Accepting self as different	35/5-9	'it is not necessarily wrong or you know

		insufficient it's just an alternative'
Internalization of BED/Part of self	36/22	'it's a big part of who I am'
Does not define self/one part of self	36/22-23	'it's a big part of who I am but I wouldn't say it defines who I am as well'
Part of life	19/28; 29/23-25; 29/28-29; 36/10-12	'itspart of what got me to this point'; 'it's always something that is there at the back of my mind'; 'once you suffer from it..you will always be conscious of it'; 'once you go through something like Binge Eating Disorder and experience it's something that always stays with you'
Ambivalent acceptance	6/35-7/1-4; 23/7-10	'I've never been to a point where I…fully attribute the blame for my eating'; 'thinking of..do you actually have an eating disorder if you binge'
Self-help as competence and control		
Trying to understand/self reading	27/12-14	'aware of umm cognitive behavioural therapy'
Individuality in treatment	27/20-26	'your own situation is so very different from everybody else..take those tools and adapt'
Self help instils control	28/32-35	'a degree of self awareness and and..control to be able to stop yourself from getting those binges'
Homosexual sexuality stereotypes		
Sexuality stereotype appearance	30/29-33	'they are more required to look after their looks and their body'
Emotional expression sexuality stereotype	31/1-4	'from that female perspective as well to be able to kind of say emotionally how they feel where is it from a kind of more dominant homosexual'
Physical appearance emphasis	31/15-16	'we are under a lot more pressure because we do have to kind of take care of our body'

Appendix J: Table of superordinate themes and constituent sub-themes excluded from the analysis

Danny
The body as perceived and lived
The body as distinct entity
Understanding own body
Overwhelmed self over binge eating conveyed through negative thinking modes
Rumination/excessive thinking
Excessive thinking over food
Catastrophic and all-or-nothing thinking modes
Excessive thinking
Rumination/catastrophic and all-or-nothing thinking modes
Early life influence on relationship with food
Family role in developing relationship with food
Constant value and importance of food growing up
Emerging identity through gender and sexuality
Identity of western man search
Critical sense of time in male identity search
Emerging identity through gender and sexuality
Emerging identity as fitting in gay subculture
Emerging identity as a gay man over time
Emerging identity through gay community exposure
Multiplicity of types of gay men/of being
Gay subculture's emphasis on physical appearance
Huge emphasis on physical appearance by gay subculture
Gay culture pressures
Exercise central feature in gay subculture
Body shape and size as fitting ideals in gay subculture
Muscularity and thinness ideals in gay subculture
Gay pornography conveying masculinity ideals
Gay subculture's influence and impact on straight subculture
Increased pressures on gay than straight communities
Gay subculture's influence on straight subculture
Gay and straight subcultures share many similarities on masculinity ideals
Body dissatisfaction
Body dissatisfaction
Body shape dissatisfaction

Bulimia nervosa compared to BED Purging behaviours as self-harm Different treatments for BN(self-sought) Diagnostic shift
Tom
One-dimensional way of being One dimensional way of being One dimensional way of being/self as stereotyping
Fear of being fat Fear of being fat Physical appearance and drive for thinness Body dissatisfaction and body checking
Acceptance process Disclosure as admission to BED Facing up to BED
Coping with BED Normalization and minimization of BED Normalization and minimization of BED diagnosis Defense mechanism as coping skills
Affect dissociation Affect dissociation Emotional difficulty/lack of emotional intelligence
Chris
Early life experiences in developing dysfunctional eating Difficult childhood Paternal control over forced eating Developing problematic eating relationship with food Traumatic adolescence Instability and uncertainty Loss of family stability Strict food rules obedience Food extortion Understanding BED development Continuous fear of abandonment Unprotected and vulnerable self

Surrender self to overpowering BED Power struggle (BED and self) Surrender self to BED BED in control of self BED overpowering self Uncontrollable subconscious Overpowering BED Loss of self in BED
Large quantity and accessibility to forbidden food Excessive eating 'Bad fatty food'/Forbidden food Convenient binge food/Easy and accessible Evolving binge preferences Expand binge eating
Humiliating weight struggles signal BED problems Weight signalling BED problems Struggling to control weight fluctuations Ridiculed for weight Criticised and humiliated Struggling with weight Instability (eating patterns/emotions/weights)
Multiple triggers heightening binge eating vulnerability Specific food triggers vulnerability Negative feelings (triggers) Negative thoughts growing into a binge
Homosexual sexuality stereotypes Sexuality stereotype appearance Emotional expression sexuality stereotype Physical appearance emphasis
Sam
Minimization as denial Difficult process of acceptance Difficulty admitting to ED Minimization (acceptance) Minimization as coping (acceptance and denial) Understanding as a difficult process

Jack
Fear of change
Fear and ambivalence/letting go of control
Ambivalence
Fear and ambivalence
Fear of change
Improving self
Breaking down
Struggling against BED personification
Self perception
Hiding and avoiding weight stigma
Self-contradiction (avoiding weight stigma)
Compare self with others
Thin and successful others
Weight comparison
Difficult process
Acceptance struggle
Long-term struggles
Admission struggle
In-denial
Issue of acceptance
Ambivalent relationship with food
Pleasure and meaningful
Taking precedence
Food precedence
Unimportant and meaningless (food-contradictions)
Peter
Role of difficult childhood in developing BED
Abusive childhood
Stress and pressure
Problematic father relationship
Misbehaving punishment
Understanding predisposing factors
Difficult adolescence
Terrified
Exercise abuse as catharsis
Binge eating counterbalance
Excessive exercise abuse
Fight against binge eating
Exercise as catharsis (regret and remorse)

Seeking redemption for sinful behaviour Sinful act Regret and redeem Redeem Breaking rules: good vs bad
Building a healthier relationship with self Self compassion Criticizing self dialogue Self-critical
The large variety and quantity of binge food Large food quantities Fast food drive through Sweets and chocolates 'Sugar belly'
Physical pain signalling end of binge eating Physically sick Fear of running out of food Physical pain
Negative thinking modes Excess thinking/over-catastrophising All-or-nothing thinking
Striving for thin perfection Thin/Perfect weight as sexual attractiveness Physical embodiment of perfection Striving for thin ideal One dimensional way of being Perfection stamina Thin as perfect greatness Push self limits Obsessive drive for thinness Unhealthy means to achieve thinness (strive for thin ideal) Fear of gaining weight Weight checking Denying negative consequences
The body as a separate container Body as distinct entity Body as a container

Appendix K: Master table of themes across participants

Master Themes	Super-ordinate theme clusters	Participant super-ordinate themes with quotation references (Page/Line number)
The experience of BED	The dual facet of BED	Peter: Diagnosis as hopeful epiphany *'puzzle' (2/13-14)*
		Tom: 'Relief': consequences of BED diagnosis '*there is a name to it' (3/7-10)*
		Chris: Futile diagnosis: finding and losing hope in recovery *'realisation' (5/5-6); ' got a term for that' (20/22-28)*
		Sam: Avoiding a confusing and unexpected diagnosis to decline the unhealthy self *'I didn't want to recognise' (17/30-31)*
		Jack: Imposed diagnosis as overpowering self '*I don't really like labels' (4/27-30)*
		Danny: Psychological consequences of BED diagnosis *'having any kind of failing or flaw' (17/9-10)*
		Chris: Dual positive and negative consequences *'enjoying the experience..the negative emotions that come back'(34/4-6);'good at hiding (4/5-6); 'demented..tone of bricks..its really it is such a shock to the system' (34/12-15)*
		Jack: Rewarding strength *'I can deal with whatever there is to deal with'(7/16-22)*
		Peter: Binge 'party': pleasure and satisfaction '*best party I ever had in my life'(11/12-19); 'enjoy my binge as best as I could' (17/30-31)*
		Peter: Dissociation from unwanted reality *'faced with reality'(12/9-11); 'food became a way to get rid of it' (15/29)*
		Danny: The distractive consequences of binge eating *'I am wearing my bingeing' (29/15-21); ' pain..add to my stretch marks..disgusted with myself' (12/12-17); 'you gain weight relatively incrementally' (30-26-35)*
		Tom: 'Sugar hangover': the shame in binge eating *'wake up with almost a sugar hangover.. not a good place to be' (5/14-15); 'waited for everyone to go to sleep or to bed so that they wouldn't hear me' (5/1-3)*
		Sam: Negative consequences *'shouldn't have done it and you just kind of feel horrible' (5/23-26); 'feel stupid after sorry for yourself' (7/17-18)*
		Jack: Regretful failure

		'not gone let it happen again' (7/28-31)
		Peter: The negative consequences of binge eating *'bullet ball in your stomach'(12/30); 'weight fluctuated a 100pounds I was up and down'(13/15-16); 'very embarrassed you know I was good at hiding'(13/7-11)*
	The futile struggle of self-control	Danny: Control as a continuous struggle over food, weight and self '*get my overeating under control' (2/4-5); 'its a complete loss of control' (2/13); 'this excess this complete out of controlleness' (23/32)*
		Tom: Struggling to control binge eating '*pour myself out..little bit turns into a bit more' (5/5-7)*
		Chris: Compelling instinct: the loss of self-control *'instinct that takes overt..compels me to do it' (5/16); 'without sort of any degree of control of myself' (12/13-14)*
		Sam: Breakdown disciplined control *'can't hold it anymore' (2/33); 'you are not yourself' (5/18-19)*
		Jack: Overpowering loss of control *'would have a go without thinking about it' (7/14)*
		Peter: Unstoppable and uncontrollable: slipping away *'feel yourself going it's going to happen' (10/23-33); 'always went..they were thousands of times' (11/1-2)*
	'Binge frenzy': the experience of dissociative craziness	Chris: Intense craziness *'frenzy..just blurred out from myself' (8/23-27); 'binge frenzy' (15/3-4)*
		Peter: Experience BED as craziness and insanity *'mighty binges all night long..very insane' (7/27-30); 'I was crazy that i was uniquely flawed' (13/6-12)*
		Chris: 'Silent movie': experiencing dissociation from self *'an out of body experience' (15/6-8); 'silent movie so then a click of a switch..rush of emotions' (15/11-15)*
		Jack: 'Out of body experience' '*a feeling of dissociation.. out of body experience..not being able to stop lack of control' (4/18-20)*
	Living with BED	Danny: Living in shame and isolation *'really shameful about binge eating..compounds the isolation..you're an oddity..as if you are completely*

		alone' (31/12-21)
		Tom: Impaired life *'massively..gigantic' (6/15-16); 'stop myself from being happy' (11/16-17)*
		Chris: Living a constrained life *'very difficult to kind of sit and eat anything' (1/26-32); 'mentally taken really big toll' (6/13-20)*
		Jack: Ideal life made numb and partial by BED *' whole life not having necessarily taking on 100%' (14/24-28)*
		Jack: Living with an unwanted weakness *'going to be with me for the rest of my life' (18/1-3); 'I didn't like to have the weakness' (18/33-35)*
		Peter: Living with a shameful stigma *'still embarrassed by it cause I am a man' (2/34); 'I didn't want to look like a crazy person' (3/25-32)*
		Chris: 'Negative negativity': locked in a vicious cycle *'negative negativity..step away fromfitting in that cycle' (15/22-24); 'chain of thought that would then become increasingly regular' (11/33)*
		Sam: 'Cycle of doing': trapped in an inevitable cycle *'have a cycle of anxiety..it happened again..don't want to get into that cycle of doing it but its inevitably it's going to happen' (7/2-22)*
		Jack: Trapped in a vicious cycle *'same circle for all of my life.. over and over again you know same story' (18/26-29)*
		Peter: 'Dark dark world': inescapable trap *'I always feel like umm recovering..have been in that dark dark world' (24/6-9); 'I thought that was who I was going to be for the rest of my life it was pretty hopeless' (2/1-2)*
		Chris: Fragile sense of improvement *'take so many knocks but if I go one further that's then going to set me even back' (21/30-34)*
		Chris: Hopeless recovery: learning to live with BED *'it's always something that is there at the back of my mind' (29/23-24)*
		Tom: Coping with BED *'I am not ashamed of it..it is kind of what it is' (11/26-68)*
		Jack: Recovery as an ambivalent process *'so cut to the core hard and dry that I just I have struggled with it' (15/17-23); 'change all that I have known for all of my life...scariest thing' (19/6-9)*

		Jack: Strategies to cope with BED *'it's just his little piece I got to change' (9/19-21)*
		Peter: The constant process of recovering *'we all get better in our own way' (18/9-12); 'getting there is like starting over' (25/3-7)*
The process of understanding	Turbulent quest: in search of an understanding	Danny: Lack of EDs awareness develops into extensive knowledge '*deliberately taught myself to be able to figure out' (37/1-3)*
		Tom: Understanding BED as emerging and conflicting *'why am I doing this? I didn't know' (3/31-33); 'there is an understanding this might not be correct' (4/6-7)*
		Chris: Binge eating: food evolution in complicating men's' roles *'an evolutionary thing' (32/20-27); 'availability of the food' (32/33-35+33/1-3)*
		Sam: Understanding BED as a mental problem *' in the brain as suppose to being physical' (4/16-17)*
		Jack: Lost in overwhelming confusion *'nervous of going to sleep or wasn't an issue of falling asleep' (6/18-22); 'you've got these loops going on in your head' (7/10-11)*
		Jack: Questioning own self in search of an understanding *'I don't know how to deal with them and I am going crazy' (2/5-7)*
		Peter: Struggling to understand BED '*make yourself feel better for a horrible experience'(11/4-8)*
	Food addiction	Danny: Understanding binge eating as self-harm and addiction *'your addiction is food itself' (5/25); 'becomes the behaviour that makes you feel better' (13/24-27)*
		Tom: Harming self *' trying to stop myself from being happy' (11/16-17)*
		Chris: Food addiction: craving unattainable happiness *'haven't had that I need to have that..becomes the addiction' (33/12-27)*
		Sam: Addicted to bingeing *'like an addiction like smoking' (1/27-30); 'you are so..addicted..to like bingeing' (6/24-25)*
		Jack: Understanding BED as an addiction 'abusing food I abuse food like other people abuse drugs alcohol' (8/3-5)
	Functionality of BED	Danny: Positive functionality of binge eating*'the binge serves as a vacuum..nothing is happening..I am no one' (18/4-7); 'protection mechanism';*

		(29/22-27); 'trying to be protective..becomes a way to escape' (30/14-26)
		Sam: BED as affect regulation *' feel quite relieved' (2/35)*
		Jack: Escape negative affect *'use food as an escape' (1/30-32); 'I don't have to deal with it..so escape' (10/1-2)*
		Peter: The function of BED in escaping and protecting self *'people do disorders because they work' (16/27-29); 'a toll a weapon' (17/23-26); 'make me feel better' (18/2-4)*
The stigmatised male self	Male stereotype: being a 'macho male' man	Danny: Masculine perfection: thin and muscular ideal *'had to be perfect in a physical way' (22/10-11); 'Greek god' (29/6); 'rippling muscles' (19/11-19)*
		Danny: Male behaviour stereotype: manliness and masculinity *'acceptable for men to routinely overeat' (4/3-4); 'not the amount of food you put in front of a bloke' (20/1-3)*
		Tom: Gender stereotypes associated with food, emotions and behaviours *'not overly bothered about food (9/4-7); 'as a bloke..it is acceptable to eat a lot' (7/33-8/1)*
		Tom: Self-comparisons to athletes *'comparisons to role models..footballers who have a good physiques' (6/30-31)*
		Chris: The 'macho male' man *'the macho kind of image...fitting in with everybody else' (18/1-10); 'a guy was the guy' (24/14-19)*
		Sam: Sense of belonging: fitting in thin and muscular ideals *'prefer to be more muscular' (11/20); 'fit in..to mesh but not not to stand out' (10/5-7); ' want to be a lad' (12/10-29)*
		Sam: Exercise as transforming self into the ideal man *'I am very into my sport' (2/8-9); 'i was going to join the royal marines' (7/29-35)*
		Jack: Distinct gender behaviour stereotypes *'a man can be a little bit more out of control' (12/20-23)*
		Peter: 'Macho male' personification *'come from that the macho male (deepening voice) aspect' (6/10-12); 'officer of the marine court' (13/24-25)*
	The stigma of BED	Danny: 'Greedy': BED stigmatization of character *' greedy you've just umm cant control yourself around food' (5/8-18); 'needs to have more will power' (17/25-28)*
		Tom: 'Girl thing': self unfitting male stereotype '*a girl thing to or a female thing' (8/32-33)*
		Sam: Homosexuality and EDs *'a gay person as*

		more likely to have an eating disorder than a straight man' (14/20-21)
		Sam: Adhering to EDs stereotypes to hide ED *'they wouldn't expect me having an eating disorder' (12/7-9)*
		Jack: BED as socially acceptable manly behaviour *'reinforcing the fact that you are a man because you can binge eat' (12/24-30)*
		Peter : The stigma of BED on men '*he is weak he has this woman thing'(3/13-14)*
		Peter: 'Woman's thing': BED as a rare male disease *'getting a disease that is rare' (21/23-28); 'reinforce that feeling that it's a women's thing' (5/24-25)*
		Peter: Gay 'effeminate' EDs stereotype *'more effeminate' (6/19-21)*
		Chris: BED stigmatization: rare disgraceful marginalization *'there would be a bundle of jokes fun poking (28/10-14); 'the stigma..stepping forward' (17/17-19)*
		Chris: Male stereotypes concealing BED *'the guy always eats the bigger portions' (16/16-19)*
	Sense of self	Danny: A self that cannot be found, understood or accepted *'internalized battle' (29/10-14)*
		Danny: The influence of others on self-perception and self-worth *'I felt completely misunderstood..they didn't understand it at all' (15/1-11)*
		Tom: Experiencing a disciplined self as weak *'unacceptable or not appropriate' (2/34); 'you are not good enough' (3/16-17)*
		Peter: Perception of self *'you are weak you are specifically flawed' (1/26-34)*
		Peter: Failure to attain perfection *'think less of yourself..makes you feel umm very insane very weak' (7/25-33)*
		Chris: Negative perception of self *'felt repulsed for looking at myself' (6/26-28)*
		Chris: One part of self, not all of self *'it's a big part of who I am but I wouldn't say it defines who I am as well' (36/22-23); 'always stays with you' (36/10-12)*
		Sam: The vulnerable self *'you think will never happen to you' (4/18-23)*
		Sam: Judging and comparing self to others *'everybody very fit' (9/30-32)*
		Sam: Part of self *'you have this urge that is build up inside of you'*

		(3/1-2)
		Jack: BED as transforming self *'I am very powerful and and this thing makes me weak' (19/22-25)*
		Jack: Not part of self *'its not ingrained in me you know it's not part of my DNA' (4/32-33)*
The experience of treatment	Seeking and accessing treatment: Struggling alone in search of unavailable support	Danny: Professionals' lack of information, knowledge and understanding in BED *'she was completely stumped' (37/25-34); 'terrible depression or some kind of episode a break down' (40/23-24)*
		Danny: Sense of isolation as a man with BED *'felt isolated..you're an oddity' (31/5-21); 'I've not known a single one yet'(33/26)*
		Tom: Lack of knowledge and information *'am I diabetic? am I..just greedy?' (3/28-29)*
		Chris: Lack of BED recognition and exposure *'the media kind of always highlights the..female side of things' (16/26-29); 'not been seen as particularly big problems' (23/18-21); 'I've never heard of it..being a male thing' (18/21-25)*
		Chris: Sense of isolation: helplessly struggling alone *'there isn't as much support as much as you kind of need it or expected to be there' (22/4-8)*
		Chris: Misunderstanding BED: suffering without knowing *'any kind of problem until I was round about 22-23 years old' (1/4-19); 'oh well he's got a big appetite' (17/1-3)*
		Chris: Seeking help barrier: self-inflicted stigmatization *'I am not like the rest of...the male population' (26/1-2); 'stepping away from the stereotype' (28/3-19); 'always worded towards women' (16-4-6)*
		Sam: Suffering in isolation *'you can't vocalize it you can't..describe it to people..it's pretty tough' (13-33-35)*
		Sam: BED misunderstood by others *'thought I was gay' (14/28-29); 'I don't think he understood' (17/9-17)*
		Sam: Accessing treatment challenges *'I haven't heard anything else like that' (18/31-35)*
		Peter: Inadequate information and treatment provision in misunderstood BED *'very little mention of men' (18/32-34); 'don't get people who understand eating disorders' (19/24-25); 'I would think they are gay' (5/33-35)*
		Peter: Seeking help barrier: fear of stigma *'won't come forward they won't seek therapy because of the stigma' (5/9-11)*

		Peter: Overcoming treatment barriers: the difficult process of seeking and accessing treatment *'really tough for a guy to having to go through this whole process' (20/7-8); 'get guys to open up' (22/15-16); 'guys standing up, resources being there' (22/34-35+23/1-3)*
	Challenges in receiving treatment	Danny: 'Nothing else on offer': inadequate treatment care provision and options in EDs *' nothing else on offer' (35/2-3); 'it's too scary too risky' (39/31-37)*
		Tom: 'Nuthouse: frustrating yet beneficial treatment *'nuthouse.. everyone wanted to shout their stuff out' (10/9-12); 'people going on and on...stop bingeing' (9/23-24)*
		Chris: Experience of receiving treatment as inadequate and insufficient *'just being dropped' (29/10-21); ' any treatment for binge eating disorder' (21/11-18)*
		Peter: Positive experience of treatment *'a possible answer to make us slow it down to make it stop' (22/20-23); 'it was a wonderful experience' (19/29-32)*
		Chris: Self-help as competence and self control *'take those tools and apply them to your own individual circumstances' (28/32-35)*
		Jack: Self-help treatment as eating behaviours control *'walk a lot and I wouldn't eat very much' (13/25-27)*
		Peter: Self reading as control and worthiness *'felt so good about the progress' (19/10-14); 'privacy of your own home' (22/7-8)*
		Peter: 'Not enough': self-help as inadequate and wasteful *'go get help now' (21/1-3); 'that not enough you really need a therapist' (22/9)*
	Treatment focusing on men	Danny: Tailoring treatment: all male group therapy *'there is more need for treatment that is tailored to men' (36/11-13); 'go where there is going to be eight eight men sitting around..don't feel..judged overcome stigma' (38/20-29)*
		Tom: Stigma and time treatment recommendations *'lucky enough to have a couple more guys in there' (11/7-9)*
		Chris: The benefits of male group therapy *' talk to males and guys who have gone through the whole process' (27/28-31)*
		Chris: Male specific treatment recommendations *'lack of support and empathy' (25/27-79); 'take*

		somebody whose actually gone through the experience' (25/30-34)
		Chris: Normalise BED in men *'I am human i am the same as everybody else' (17/29-33); 'you are not the only one' (18/12-18)*
		Sam: 'Something should be done by counsellors': recommendations to professionals '*start this group..something should be done by counsellors'(19/8-12)*
		Peter: Strategies of normalization and breaking stigma to improve treatment offered to men *'something that men and women share pretty equally' (21/28-32); 'guys too there is some of you' (22/11-14); 'having a resource so that there is a place to go to is definitely talks about men' (21/33-34)*