Sculpted and Starved: A Discourse Analysis on the Gendering of Eating and Body Image Disorders

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Abstract:

Drawing on anthropological work on the social and culture significance affixed to the presentation and modification of the body, particularly the male body, my thesis analyzes the medical and social discourse surrounding eating disorders and body image concerns. In particular, this thesis will explore questions such as: How are eating disorders and body image concerns conceptualized in the literature and in the clinical setting? How are they depicted in public discourse, both historically and in modern-day Western society? What impact does this discourse have on men suffering from eating disorders, either in terms of receiving a diagnosis or getting treatment?

My thesis argues that, despite the growing prevalence of male eating disorders and the reality that men are facing increasing societal pressures to obtain the perfect body, eating disorders and body image concerns have been gendered as female in both medical and social discourse. Furthermore, by incorporating clinical eating disorder studies, memoires and interviews featuring male eating disorder patients, and autoethnography detailing my own lived experiences, I demonstrate how the gendering of this discourse as female has resulted in eating disorders often going overlooked in male patients and in serious barriers that prevent men from getting the support and treatment that they need.
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the absolute best thing he could have done for my recovery, which was interact with me
as if everything was fine and I was my same old self. He called me out when it was
needed – i.e. when I was breaking a miniature peppermint patty into five small pieces
when we were doing research at the library – but otherwise was the noninquisitorial
solace I needed whenever I wanted to pretend that nothing had changed.

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Table of Contents:

Introduction ............................................................................................ 7

A Note on Autoethnography ............................................................... 8

Memoirs of “Manorexia” ................................................................... 11

Chapter 1: The Symbolic Body ............................................................. 12

The Body ..................................................................................... 14

The Male Body .............................................................................. 17

Chapter 2: The Male Body Emerging ..................................................... 21

Chapter 3: Eating Disorders ............................................................... 27

A Brief History of Disordered Eating ................................................... 27

Cultural Model of Eating Disorders .................................................... 29

Eating Disorder Prevalence ............................................................... 32

A Gendered Paradigm ................................................................... 33

Muscle Dysmorphia ....................................................................... 44

Chapter 4: “Stylized Acts” ................................................................. 47

Gendering of Behavior .................................................................. 47

Bodybuilding ................................................................................ 51

Gendered Spaces .......................................................................... 58

Conclusion ........................................................................................ 60

Power of the Established Discourse .................................................. 61

Moving Forward ............................................................................ 63

Adding Men to the Discourse ............................................................ 64

Bibliography ................................................................................... 66
I remember the day clearly – the day my eating disorder truly started. I was a sophomore in high school, I had just finished my soccer season, and it was during the twenty-minute break we were allotted halfway through our morning classes. I was hungry and, not having brought any food from home, I went to a vending machine and impulsively bought a pack of Hot Fudge Sundae Pop-Tarts. Reaching down to retrieve my haul, I realized that my selection was far from the healthiest option and, seeing as I no longer had soccer practice, it may be too indulgent. I decided to only have one, putting the second one away in my locker for another time, but found myself going back for the second one within ten minutes. Somehow, this snack got to me more than others had – to my shame, this was far from the first time I had had multiple Pop-Tarts as a snack – and I made the seemingly rational decision in that moment that I would use my mom’s old elliptical at home to burn off the calories of my mid-morning indulgence when I got home from school. And, at the end of the school day, I did just that; I went home and ran on the elliptical until the little screen told me that I had burned 380 calories – the exact number that I had read off of the plastic wrapper. That was when it all started.
Introduction

This thesis argues that, despite the growing prevalence of male eating disorders and the reality that men face societal pressures for obtaining the perfect body, eating disorders and body image concerns have been gendered as female in both medical and social discourse. Furthermore, this thesis seeks to demonstrate how the gendering of these discourses has serious clinical implications for men suffering from eating disorders, both in terms of receiving a diagnosis and getting treatment. First, I will present anthropological theory on the symbolism of the body and bodily acts, referring heavily to the works of Susan Bordo, Judith Butler, and Mary Douglas. In Chapter 1, I will review how the body is affixed with cultural and social importance as well as show how the eating disorders and the manipulation of the body have come to be studied predominantly by feminist theorists. I will then move into the anthropological discourse surrounding the symbolic male body, where again I will draw heavily on the work of Bordo. From this conceptual framework, in Chapter 2, I will specifically look at how the male body is presented in society, both historically and in modern-day consumer culture, in order to showcase the cultural pressures that the twenty-first century male faces in terms of embodying particular cultural ideals of masculinity. In Chapter 3, I will demonstrate how eating disorders and body image concerns are conceptualized in the clinical setting as well as how they exist in public discourse, drawing on clinical studies, memoirs and interviews of male eating disorder patients, and feminist scholarship. In Chapter 4, I will look at how the gendered discourse surrounding eating disorders, body image concerns, and the “stylized acts” of body beautification have implications for men suffering from eating disorders. Specifically, in this chapter, I will highlight how the gendering of
certain symptomologies and different types of body work – i.e. bodybuilding versus extreme calorie restriction – play an enormous part in the gross under recognition of male eating disorders. Finally, in the Conclusion, I will discuss the power of creating this gendered discourse, drawing on the work of Emily Martin, as well as make a case for adding men to this discourse. In addition, I push for more work to be done in the field of male eating disorders in terms of getting a better understanding of the cultural underpinnings responsible for the recent rise in male patients and designing more accommodating diagnostic and treatment models. In addition, interspersed throughout and running parallel to this discourse analysis will be my autoethnography.

A Note on Autoethnography

Autoethnography is an approach that “seeks to describe and systematically analyze personal experience in order to understand cultural experience,” incorporating tenets and characteristics of both autobiography and ethnography (Ellis et al. 2011). Concerned with the cultural connection between the individual and others in society, autoethnography is distinct from other narrative-oriented writing styles, such as autobiography or memoir. Furthermore, autoethnography, representing both a methodology and a text, can take a variety of forms, such as stories, poems, fiction, novels, photographs, and social science prose (Humphreys 2005).

The expression “autoethnography” was first introduced by anthropologist Karl Heider in 1975 and has since become increasingly popular in a range of disciplines. The undeniable strength of autoethnography and arguably the reason for its popularity is its ability to connect the personal with the cultural (Humphreys 2005). Many anthropologists have touted the benefits of autoethnography, arguing for its unparalleled
ability to increase author-reflexivity and dispel any accusations of only skimming the surface of the subject (Humphreys 2005; Pelias 2003). There is also an established precedent for the use of autoethnography to explore the subject matter of eating disorders in response to previous writings that sought to simplify the complex nature of anorexia and bulimia (Mukai 1989).

In this thesis, I use autoethnography to interweave my own experiences as a recovered male eating disorder patient with the theoretical discourse attempting to explain how and why eating disorders are on the rise among male patients. Similar to most autoethnographic works, I will be writing about and analyzing my experiences retrospectively, as I was diagnosed with anorexia nervosa at the age of fifteen (seven years ago), as a sophomore in high school. Using this method, I am able to position my own story within the story of the social context surrounding my experiences. In addition, the use of autoethnography in this thesis allows me to span the divide between scholarly inquiry and individual experience, acknowledging the fact that this scholarly inquiry is inseparable from who I am and my lived experiences.

I am cognizant of criticisms of autoethnography as a methodology in terms of validity and generalizability as well as worries over reliability and memory recall, but the period of my life about which I am writing has been well documented and I have done my best to articulate my experiences in written language as closely to how they were actually lived and felt. In addition, I am aware that autoethnographies are often critiqued for being “insufficiently rigorous” as well as being biased, narcissistic, too aesthetic, too emotional, and atheoretical (Ellis et al. 2011). Nonetheless, I have chosen to include one because I believe a “deep description” of the cultural processes surrounding male eating
disorders is an integral component of this thesis, as the affective, experiential aspects of anorexia nervosa can only be understood and captured through lived experience.

Similar to the concept of “thick description” adopted into anthropological parlance by Clifford Geertz in *The Interpretation of Cultures* (1973), the “deep description” I am producing with my autoethnography is meant to provide context and to evoke an emotional response. However, just as autoethnography is methodologically distinct from ethnography, the description I am creating with my autoethnography is not perfectly synonymous with Geertz’s “thick description,” which is why I have opted to coin the term “deep description.” Unlike Geertz’s notion of “thick description,” my “deep description” will focus primarily on internal experiences and will have the benefit of a self-analytic vantage point. In addition, as I will not be analyzing the behaviors of others and attempting to ascribe meaning to those behaviors, my “deep description” will be less interpretive in nature.

It would have been productive to interview a cohort of men and boys who have also suffered from an eating disorder, but the ethical considerations and time constraints of this project made such a venture infeasible. Though I realize that the context surrounding my experiences and perspectives is not universally applicable and in several ways I am in the minority of male eating disorder patients because of my treatment resources and my full recovery, it is my hope that my story will open spaces for thinking and considering the gendered discussions of eating disorders more carefully. Furthermore, I know that not many people are able to win the battle that I fought and, in addition to being proud to be one of my doctors’ success stories, I feel that
adding to the discourse surrounding eating disorders, particularly in males, by writing this autoethnography is something that I have an obligation to do.

*Memoirs of “Manorexia”*

Though the autoethnographic components of this thesis are the primary source for a “deep description” of the cultural processes surrounding the emotional experience of male eating disorders, I have also chosen to complement my autoethnography with a collection of interviews of male eating disorder patients. These interviews have all been published, are publically available online, and in no case am I the interviewer, but I believe that their inclusion in this thesis provides important experiential evidence to compliment my own narrative.
Chapter 1: The Symbolic Body

Growing up, I was always on the heavier side. Never technically fat, thanks to my ever-climbing height, but always far from comfortable taking my shirt off during soccer practices and days at the beach. My pediatrician said that my weight was going up “according to plan,” and neither him nor my parents were ever concerned. Regardless of the medical opinion, I never felt particularly confident in my appearance. I wanted desperately to look like the lean, built guys I saw in movies and on magazines – the ones who exuded confidence, the ones who looked good in anything and took their shirts off at the beach without a second thought, and the ones to whom everyone seemed to flock. I even came to envy my friends and brother, who all just seemed to naturally have the athletic physique and accompanying confidence that eluded me. However, during my first year of high school, that had started to change. Getting taller combined with regular tennis lessons and more intense soccer training was finally getting me closer to the physique that I had wanted and envied in my friends for so long. My tennis team had just gone to the state championship and I had been made junior-varsity captain of my soccer team. In a very narcissistic way, I finally felt like an athlete.

Looking back, that’s what made this mid-morning Pop-Tart so striking. My soccer season had just ended and, in my head, this meant that I was at risk of slipping back where I had been before. I felt that if I wanted to stay where I was or, ideally, progress further toward my ideal body, I needed to do something. I could watch what I ate and exercise on my own. I could be like those archetypal driven, goal-oriented people...
I see in movies and on television – the ones who excelled at school and work, constantly on-the-go and overwhelmed with responsibilities and jobs to do, and still managed to squeeze in workouts and look like models. I already approached my studies with a certain level of tirelessness and obsessiveness, why couldn’t I take charge of my body the same way? If I did all of that, I thought, I would end up looking like one of the guys from the movies.

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The Body

In recent decades, the notion of the human body as static and as a biological given has been extensively overturned and rebuked, replaced by a view of the body as a sociocultural and historical phenomenon (Bourdieu 1997; Douglas 1970; Foucault 1979; Reischer and Koo 2004). In addition, there has been a surge in academic interest in the social meanings of the ways in which we as humans modify, adorn, and make our bodies “beautiful” owing to the recent prominence of the human figure and body modification practices in popular culture (Reischer and Koo 2004). From this growing field of research, one of the more influential theoretical frameworks is that of the “symbolic body,” wherein the focus is “on the representational and symbolic nature of the body as a conduit for social meaning” (Reischer and Koo 2004). Akin to this approach is the theoretical tradition that proposes that the modification and beautification of the body is a mechanism of social power and control (Bordo 1993; Butler 1990; Grogan Reischer and Koo 2004).

It is well expressed within the literature that the body can be a vehicle for the expression of core social values (Bordo 1993; Butler 1990; Reischer and Koo 2004;
Shilling 1993; Stearns 1997). One of the original articulators of this notion, Mary Douglas, argues in her canonical work *Natural Symbols* that social norms and meanings are readily inscribed on and reproduced through bodies and bodily symbols (1970). This proposal that our bodies possess an impressive capacity for symbolic representation then spurred later theorists, particularly feminist scholars, to observe that the body has the potential to exhibit cultural values (Reischer and Koo 2004). Characteristic of this work is Susan Bordo’s *Unbearable Weight: Feminism, Western Culture, and the Body*. In this book, Bordo proposes that bodily appearance conveys a message about the self, noting that the size and shape of an individual comes to signify their moral, emotional, and spiritual state and their internal capacity for self-control. In most Western cultures, she argues, “the firm, developed body” serves as a symbol for having the proper attitude and the “willpower, energy, control over infantile impulse, the ability to ‘shape your life’” (1993). For Bordo, these symbolic meanings concerning firmness and the absence of loose fat are the result of the social symbolism of body weight and size (1993).

Following this train of thought, Naomi Wolf, another feminist scholar, and others have discussed how these body ideals can go even further, becoming mechanisms of social power and control (1991). According to Wolf and other theorists, the slender body ideal is not merely a symbol of social values regarding excess fat, but also serves as a representation of the internal willpower and discipline that goes into obtaining such a body (Bordo 1993; Goffman 1976; Nichter and Nichter 1991; Wolf 1991). It is only through intensive reshaping of the body and a constant vigilance against indulgence that one can hope to obtain this beauty ideal, and, as Wolf argues in *The Beauty Myth*, can women hope to find professional success (1991).
These feminist views on the symbolic body have naturally translated to a feminist interest in eating disorders. As many feminist theorists argue, the inundation of slender female bodies in mass media coupled with the desire to demonstrate the internal discipline necessary to achieve such a slender body ideal has led to the significant rise of eating disorders in recent decades (Bordo 1993; Nichter and Nichter 1991; Wolf 1991; Reischer and Koo 2004). In her work, Bordo takes the stance that the management of the individual body is tightly connected with the management of society through consumer culture; the feminine slender ideal is the physical manifestation of the capitalist ideology in that it is fed on “fantasies of rearranging, transforming, and correcting, limitless improvement and change, defying the historicity, the mortality, and, indeed, the very materiality of the body (Bordo 2003, p. xvi; Reischer and Koo 2004). Similarly, Wolf draws attention to the fact that the remarkable rise of eating disorders in recent decades coincided with the rise of women to positions of leadership and influence in the workplace (1991). According to Wolf, a storm of new cultural and professional pressures on women for having the right body shape had ushered in a new “meritocracy” of beauty, wherein the body must be carefully disciplined and monitored in its size and appearance (1991; Reischer and Koo 2004). Thus, as Kim Chernin, another feminist scholar, argues in her The Obsession: Reflections on the Tyranny of Slenderness, eating disorders are a symbolic reflection of women’s anxieties about meeting the culturally constructed ideals of the acceptable body (1981).

This feminist trend in the literature, however, points to one of the principle failings of scholarly work on the symbolism of the human figure, body ideals, beautification practices, and eating disorders: most of the literature considers only the
female body. Despite the fact that the capacity for self-management and governance has indisputably been branded as male throughout Western religious and cultural tradition, the notion of “beauty work” is usually considered to exclusively be the realm of women (Bordo 1993). Accordingly, the existing literature on the “symbolic body,” the beautification of the body, and the cultural underpinnings of eating disorders is dominated by feminist theorists like Bordo and Butler (Reischer and Koo 2004). Until the 1980s, the academic interest in body image and beauty practices was largely restricted to the female body, with the study of the male body being only a somewhat recent phenomenon (Grogan 2008).

The Male Body

Just as the slender female body has become affixed with social meaning, so has the lean, toned, and muscular male body (Bordo 1993; Bordo 1999; Grogan 2008; Luciano 2001). In fact, in many ways, the study of the symbolism of the male body has an even longer tradition than that of the female body (Stearns 1997). Muscles historically and continue to symbolize masculine power in the form of physical, brute strength (Bordo 1993; Pope et al. 2000). According to Sarah Grogan, the muscular and lean body is the masculine ideal because it is inherently tied to the Western notion of maleness as representing power and strength (2008). Echoing this is the theory that a muscular physique functions as a physical embodiment of the traditional male sex role as powerful, strong, and even domineering and destructive (Pope et al. 2000). Before examining the modern-day symbolism of the male physique, however, it is necessary to look at how male bodies, muscular or not, have previously been viewed and interpreted.
Historically speaking, the collective societal shift against fat and excess poundage was not merely a women’s issue. Male appearance has been valued in countless cultures all over the world for thousands of years (Pope et al. 2000). At the turn of the twentieth century, it was the men in society who were the target of commentary and the recipients of most of the early “fat-shaming” slang, like “slob.” When it came to the ideal male physique in society, “an appropriately slender figure could denote the kind of firm character, capable of self-control, that one would seek in a good worker” (Stearns 1997). For men at this time, fat and any excess poundage had become an easily recognizable “secular sin” that was diagnostic of moral quality (Stearns 1997). Championing this mentality was the increasingly subscribed to doctrine of “Muscular Christianity,” or “Christian manliness,” which was a conception of physical fitness stemming from nineteenth century England. The idea of Muscular Christianity, spearheaded by the popular British novelist Charles Kingsley, championed physical perfection – i.e. a toned and lean physique – as intrinsically linked to spiritual health and morality (Lindqvist 2003; Luciano 2001; Watson et al. 2005). Some critics have suggested that Muscular Christianity was an anxious Victorian England’s attempt to assert control and dominance over a rapidly changing world that was threatening religion’s place in society while others have argued that body anxieties were just a manifestation of intensifying class and male-power anxieties (Hall 2006; Lindqvist 2003; Watson et al. 2005). Along the lines of this second argument, it is important to recognize that, as the two possible names suggest, an inherent belief of the movement, not at all out of place for that time period in England, was that “manliness” was considered to be synonymous with strength and power, both moral and physical (Hall 2006). Some
historians have even gone as far as to question where Muscular Christianity stands in terms of male self-perception and Great Britain’s imperial conquest of Africa. For instance, in Muscular Christianity: Embodying the Victorian Age, Donald Hall argues that Kingsley, with his Muscular Christianity movement, helped produce a masculinist image of an imperial English power concerned with territorial and economic expansion (2006). However, regardless of the range of societal factors that gave rise to Muscular Christianity, the proximate motive of the movement is clear: exude heightened male power and morality through exercising the body (Hall 2006; Lindqvist 2003; Luciano 2001; Vance 1985; Watson et al. 2005).

Though Kingsley’s original conceptions of physical fitness were based around participation in sports along with fishing, hunting, and camping, Muscular Christianity has also been associated with what has been described as a “habit of ‘manly exercises’ that fostered the indigenous ‘constitutional energy’ and contributed to the physical and moral vigour” (Vance 1985). These “manly exercises” were most likely far from what one would see in a twenty-first century Gold’s Gym, but it is believed that these exercises aimed at enhancing both physical and moral vigor among the followers of Muscular Christianity were a precursor to today’s booming fitness industries (Lindqvist 2003). In fact, these “athletic traditions” of Englishmen were adopted by Pierre de Coubertin, who would later go on to found the modern Olympic games in his effort to reinvigorate France after their defeat in the Franco-Prussian War (Vance 1985). As will be described in great detail in Chapter 4, the initial moral intent of the health and fitness movement has since been replaced by ideals of individualism, willpower, and social dominance (Lindqvist 2003).
Contemporaneous to the "Muscular Christianity" fitness movement was the nutritional campaign of Sylvester Graham, who championed gluttony as the greatest American threat to both health and morality (Luciano 2001; Stearns 1997). Horrified by the increasingly "animalistic" tendencies in mid-nineteenth century America, Graham became an outspoken advocate of a diet centered on bran and vegetarianism – a sort of temperance movement aimed at refined white breads and meat products rather than alcoholic beverages. According to Graham, such a diet could do everything from being a source of salvation for the American man in Jacksonian America to protecting one from cholera (Brandt and Rozin 1997). Though the "Graham Diet" is mostly remembered today by being the inspiration for modern-day graham crackers, Sylvester Graham is honorably considered to be the first "food nut" and his lectures and the movement they generated cannot be ignored when considering the rise of society’s interest in diets and taking control of one’s own health (Brandt and Rozin 1997; Luciano 2001; Stearns 1997).

It was not until the 1920s that such a definite feminization of the world of dieting and body management was established. However, in the following decades, both the medical community and popular culture came to look upon fat women with an explicit disdain. Women seen as overweight were attacked with claims that they lacked discipline and were actively destroying their marriages by losing their sex appeal (Stearns 1997). It is during this period that the female body began to be more and more objectified in mass media and the advertisement and commercial consumption of beauty products promising the ideal female body skyrocketed. It is also from this period that we now have the modern-day conception of strict dieting and mainstream body maintenance as a largely feminine domain (Reischer and Koo 2004; Stearns 1997). Accordingly, scholarly
interest in the male body took a backseat to feminist studies of the female body (Reischer and Koo 2004). The male body, however, is no longer hidden from the public eye and scholarly interest has been rekindled in male body image and the cultural production of masculinity (Bordo 1999; Luciano 2001; Pope et al. 20000; Reischer and Koo 2004).
Chapter 2: The Male Body Emerging

The development of my disordered eating and relationship to exercise, despite being marked by such a precise moment of me obsessing over Pop-Tarts, did not take place overnight. Being a fifteen year-old boy, I had absolutely zero experience dieting and was taught that I did not need to because I was “fueling the growth.” I was in the habit of occasionally eating an entire meal at McDonalds or Burger King as a snack before dinner and had grown up being no stranger to seconds and thirds at meals. Furthermore, I was perfectly content to spend entire days sitting down or laying in front of the television. In other words, the fit and healthy lifestyle wasn’t exactly my cup of tea. Even so, I decided that I would make myself change, because I knew there was no way in hell that movie stars and models looked the way they did as a result of reclining on sofas and meticulously eating entire bags of chips and oatmeal raisin cookies. What started out as a conscious decision, however, would soon become something that went far beyond my control.

As any good student would, I started my crusade by doing some research. I had seen and perused Men’s Health magazines on the racks at bookstores before, but the time had come to turn the suggestions, diet plans, workout ideas, and transformation stories into action. I began to examine the nutritional information of my favorite foods, counting calories and grams of protein as if these numbers were the secret to success. Certain foods were good and others were bad. Bagels, Pop-Tarts, cheese burgers and fries from McDonald's, chicken tenders and Coca-Cola ices from Burger King, flavored lattes,
muffins, large bowls of spaghetti, anything fried, and white bread – these were all foods I could no longer eat. I could no longer eat whatever I wanted, blissfully ignorant of nutritional information and fat-loss recommendations. I even purchased a book that provided lineups of *to be avoided foods* and their alternatives at virtually every chain restaurant. I began to figure out exercises I could do at my house without any real equipment and with only an old elliptical for cardio. At the time, it felt as if the only thing standing in between me and the “perfect body” that I had coveted for so long was a prescription of pushups, crunches, and replacing some of my favorite foods with protein bars.

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In the past, men have been assumed by researchers and the medical community to be exempt from media pressure for a certain body shape, as the male bodies presented in visual media used to reflect a clothed, average male physique. A man’s prestige and attractiveness were derived from prowess at an activity or how much he could earn for his family, not whether or not he was sporting a six-pack underneath his dress shirt. Even in media portrayals, whereas females who did not meet the ideal standards of beauty could not dream of occupying the position of a romantic or sexual lead, men were able to get by with wit, intelligence, and good style. However, in recent decades, the male models and actors we see in mass media have become leaner and more muscular, straying further and further from the average male body. The number of magazines geared toward men’s fitness and the frequency of undressed men in advertisements in all magazines have increased significantly over the past few decades and there is a resulting higher pressure on ordinary men to strive for potentially unobtainable standards of

22
leanness and muscularity (Bordo 1993; Grieve 2007; Pope et al. 2000). As Lynne Luciano says in *Looking Good: Male Body Image in Modern America*, “the traditional image of women as sexual objects has been expanded: *everyone* has become an object to be seen” (2001).

Also significant is how these male bodies are being diffused to the public. In short, they are presented as a physical manifestation of society’s conception of the ideal male body and an ideal masculinity (Alexander 2003; Bordo 1999; Olivardia et al. 2004). In a study looking at recent front covers of *Men’s Health* magazines, which has been published since 1987, Susan Alexander discovered that the front cover is often nothing more than a chiseled male torso and head with an indistinct background, indicating that the model is doing nothing aside from baring his physique for his audience, playing the traditional role of a pinup girl. Furthermore, Alexander found that all of the men on the front covers were a homogenous mix of well-toned but not overly muscled bodies, all in positions showcasing their well-defined muscles (2003). Thus, Alexander argues that the most significant message about masculinity that these magazines appear to be conveying to audiences is that all men who are real men should “build and maintain a hard body” (Alexander 2003, p. 542). In other words, as was also suggested by Bordo, young men are increasingly being indoctrinated in the belief that alpha male status and masculinity “rests on one’s outward appearance rather than on the traditional male role of production” (Alexander 2003; Bordo 2000). Also of note is the fact that all covers sampled had a white male model exemplifying ideals of masculinity, but that is a subject that warrants its own investigation (Alexander 2003).
Fitness and lifestyle magazines like *Men's Health* had, for all intents and purposes, become my bible. Part of me was convinced that they would contain a fitness or nutrition trick that would change my life. Maybe if I convinced my dad to start using greek yogurt instead of mayonnaise in his tuna salad, I would end up with the six-pack I wanted. Maybe if I traded bagels with cream cheese for scrambled eggs, clothing would finally fit me the way it was supposed to fit and everything would look as good on me as it did on the model. Each article I read seemed to promise that I could morph my body into the chiseled figures emblazoned on the magazine cover.

The potential impact of this appearance of the lean, toned male physique in the public eye is not to be underestimated. Over the course of growing up, a young man is subjected to thousands and thousands of “supermale” images, all of which draw a direct link between appearance and social, financial, and sexual success (Pope et al. 2000). Just as the images of female models with unattainably flat stomachs, slender thighs, and thin waists are believed to fuel body image issues in young girls and women, these images of men with chiseled pectorals and washboard stomachs are capable of increasing body image concerns in men. Where young girls are given Barbie dolls to play with, young boys are given G.I. Joe action figures (Alexander 2003; Bordo 1999; Nichter and Nichter 1991; Olivardia et al. 2004; Strother et al. 2012). In fact, there is already a host of empirical evidence that this swell in the appearance of the male body in the public sphere has affected men’s and boys’ understanding of their self-identities and masculinity, their perception of the ideal male body in terms of muscul arity and body fat, and the preferences of women when it comes to male bodies (Alexander 2003; Frederick et al.
2007; Lynch and Zellner 1999; Olivardia et al. 2004; Pope et al. 2000). When shown a lineup of male figures varying in body fat and muscularity, adult men indicated that they were satisfied with their current physiques, whereas college men, who had grown up with increased exposure to media representations of the male body, voiced the desire to be more muscular, “because the believe that a much larger body is what everybody (men and women) finds most attractive” (Lynch and Zellner 1999). In one study of male gym-goers, there was a direct correlation between the importance the men affixed to looking good for women and the amount of time they spent weight training (Mealey 1997). In another study, the mere act of watching a television advertisement showing the idealized male physique was shown to invoke depression and increased body dissatisfaction in men (Strother et al. 2012)

Fig. 1. Male figure drawings used in the experiment which vary in muscle mass. Figures were originally used in Winitch (1993) and drawn by Barbara Alexander.

(Lynch and Zellner 1999)

At first, my parents seemed to be a combination of impressed and amused by my decision to watch what I ate and exercise independently. I remember one time we went to an Italian chain restaurant together and they wanted me to help them order with my growing mental catalogue of memorized nutritional information. I also distinctly
remember one evening when my mother came into the basement room with the elliptical and said “I’m so proud of you.” We had been out to dinner with family friends and I, feeling as though I had overdone it at the restaurant, had decided to workout even though we got back late. I took her words as confirmation that what I was doing was acceptable, if not commendable, and I was becoming one of the archetypal dedicated and driven fictional characters that I was aspiring to be.

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Of course, I didn’t tell any of my friends what I was doing. It wasn’t cool to diet or to work out for my appearance’s sake. That would make me look vain. That would make me look feminine. It was only acceptable to workout as part of training for a sport or for team practices and the only time it was socially acceptable for a fifteen year-old boy to avoid certain foods was if he had an anaphylactic allergy to them. I distinctly remember being at summer camp with an overweight boy edging close to obesity who was made fun of at dinner by all of the other boys in our cabin for eating a salad at dinner. Telling any of my friends that I was “watching what I ate” was entirely out of the question.
Unfortunately, this illness is so stereotyped in its expression that when we read about anorexia we seem to be reading the story of a single girl

(Kim Chernin 1981)

Chapter 3: Eating Disorders

A Brief History of Disordered Eating

Far predating the recognition of anorexia nervosa as a clinical diagnosis, which will be addressed in Chapter 3, fasting, food-restriction, and purging as forms of control over the body date back, at least, to medieval times. Medieval scholarship suggests that large numbers of women and girls, predominantly as an expression of religious asceticism, were regularly refusing food or exhibiting extreme forms of appetite control (Brumberg 1989; Rampling 1985). Self-starvation was not only viewed as a method for obtaining a higher spiritual and moral state by denying the body something it has an intense appetite for, but also functioned to suppress libido and managed the female body, whose contours and features were viewed as expressions of sexuality (Rampling 1985). As a notable example, Catherine of Siena, whose extraordinary restriction of food has been the focus of many historians and religious scholars, is believed to have survived exclusively on the Holy Communion – a small wafer and some wine representing the body and blood of Christ – for the latter part of her life, only occasionally accepting small amounts of uncooked vegetables and bread, which were immediately purged (Rampling 1985).

Of course, one must exercise caution when attempting to historically analyze behavior reminiscent of what are now understood as eating disorders. As the historian Joan Jacobs Brumberg emphasizes in Fasting Girls: The History of Anorexia Nervosa, even though the fasting and food restriction of historical women are suggestive of
anorexia and bulimia nervosa, the symptomatic similarities may be misleading and the use of modern-day psychiatric classifications should be reserved for describing modern-day cases (1989). Food-restricting behaviors, the human body, and even the act of eating can vary in symbolic meaning across different time periods and cultures, and accordingly cannot be expected to have the same cause (Bordo 1993; Brumberg 1989; Rampling 1985). That being said, technically classifiable as anorexia nervosa or not, fasting, extreme control of one’s appetite, and the control of the body through food-restriction represent a consistent and enduring motif of the human experience and form of expression (Brumberg 1989; Rampling 1985)

As time passed, my eating disorder progressed and intensified. My daily intake of calories became more and more restricted and I avoided carbohydrates unless I was eating with my parents. I was exercising nearly every day and trying to move around as much as possible. I developed new mannerisms to control how much I ate, such as picking my food into little pieces with my fingers so that my food would last longer and using napkins to dob any grease or oil from my food. I vividly recall breaking a miniature York Peppermint Patty – my allotted dessert for the day – into five miniscule pieces. Eating a sandwich became an hour-long endeavor, with me secretly hoping the whole time that something would come up that would prevent me from finishing the whole thing. Soon, I wouldn’t dare eat anything that wasn’t low-calorie, portion-controlled, high in protein, or touted as a miracle food for weight loss. I even remember making up an excuse so that I accidentally didn’t have any of my own birthday cake. And, if by some unfortunate turn of events I ended up eating too large of a meal or an
unhealthy snack, I spent the rest of the day obsessing over it, trying to rationalize the indulgence — “I’m just carbing up for my workout later” — and trying to do things that I had read boosted metabolism, like fidgeting in my seat or pacing while studying or reading.

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_Cultural Model of Eating Disorders_

It has been well established that eating disorders, such as anorexia nervosa and bulimia nervosa, are more prevalent in industrialized, Western cultures, indicating a substantial cultural influence in their development (Becker et al. 2002; Keel and Klump 2003). That being said, there is still a certain amount of underlying contention as to how much cultural aspects should be considered in the etiology of eating disorders (Bordo 1993; Keel and Klump 2003). Many have argued for the merits of a defined medical profile or pathological model for eating disorders, while others, most notably Susan Bordo, have made a strong case for a culturally aware model for both recognition and treatment (Bordo 1993; Brownell 1991; Grieve 2007; Keel and Klump 2003; Strother et al. 2012). A cultural paradigm for the understanding of eating disorders does away with the rigid mentality of anorexia and bulimia as purely psychopathological, instead emphasizing the learned, addictive dimensions of the disorders. A cultural paradigm of these disorders and other eating disorders would also highlight the roles of culture as primary and generative rather than merely triggering and would connect social factors to what are often cast as distortions or delusions specific to the “pathology” of eating disorders (Bordo 1993).
Those opposed to a cultural paradigm for the understanding and treating of eating disorders, and there are many, typically choose to focus instead on the possibility of underlying biological factors, or any other pathogenic situation that could help elucidate a distinct pathological profile for eating disorders. For instance, much work has been done trying to isolate a genetic risk factor for the development of an eating disorder (Trace et al. 2013). It is this medical paradigm of eating disorders that has directed nearly all clinical literature on the subject of anorexia and bulimia, despite the fact that both disorders are appearing in increasingly diverse populations (Bordo 1993). In this thesis, however, I will present an argument in the line with a cultural paradigm for eating disorders as put forward by Bordo. Bordo herself is adamant in *Unbearable Weight* that a search for a biological cause for trends in eating disorders would be fruitless, particularly in terms of trends in gender prevalence (1993).

Of course, this is not to say that biology has no place in eating disorder research or that biological and non-sociocultural factors have no contributory effect in the development of eating disorders. Bordo and others acknowledge profusely that culture is not the only player when it comes to the development of an eating disorder (Bordo 1993; Grieve 2007; Keel and Klump 2003). Responding to the critiques of a cultural approach that question its validity because it cannot explain why so many do not develop the disorder despite being in the same cultural environment, Bordo claims that an individual’s identity is not wholly formed by cultural images, regardless of how powerful they may be (1993). Furthermore, the aim of this thesis is not to suggest that medicine should have no place in the treatment and management of eating disorders. Rather, Bordo’s argument as well as my argument in this thesis is simply that interpreting
anorexia, bulimia, etc. requires, along with technical or professional expertise, an awareness and understanding of the layers of cultural symbolism that are manifested in these disorders (1993).

This period of my life is interesting because, when I look back, I can realize how far gone I was from my former self and just how much the eating disorder had blinded me to reality. At the time, however, I felt as though I was “winning” and that I was invincible. The disorder had convinced me that I was becoming an alpha male that was able to juggle school work with fitness and health, while in reality I was anything but. It made me feel like I was in complete control, but in reality it was I who was being controlled.

Without my notice and despite my constant exercise, I was becoming weaker. The amount of time I could spend doing cardio slowly diminished and it came to the point where I could barely do a set of pushups. By this point, after roughly five months of relentless exercising and trying to restrict my food at the same time, my tennis season had started and I found myself lacking the stamina to even finish a match. Instead of becoming more muscular like the guys I envied in the movies, I was becoming gaunt. I was always cold and my hands and lips turned purple at the slightest chill. I was constantly in such a caloric deficit that one time I broke into tears following a short workout when a restaurant forgot to include my baked sweet potato in my carry-out bag. My parents had begun to show concern, tentatively asking me if I was okay or suggesting that I eat more. I always said I was fine. I always said I wasn’t hungry or that I was full. I had become so adept at coming up with excuses for my behavior and

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rationalizing my episodes of weaknesses and emotional distress that I had even started to believe them myself. I remember telling my tennis coach that my asthma was acting up several times though I had not had any asthma symptoms for years.

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Eating Disorder Prevalence

Eating disorders are becoming an increasingly common mental health diagnosis in modern-day Western society, reaching into virtually every demographic (Hudson et al. 2007; Raevuori et al. 2014; Räisänen and Hunt 2014; Sweeting et al. 2015). Anorexia nervosa, an eating disorder characterized by “distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat” has been found to have a lifetime prevalence in the U.S. anywhere from 0.9% to 2.2% (American Psychiatric Association 2013; Wade et al. 2011). Similarly, bulimia nervosa, characterized by “frequent episodes of binge eating followed by inappropriate behaviors such as self-induced vomiting to avoid weight gain” is speculated to have a lifetime prevalence of 1.5-4.6% (American Psychiatric Association 2013). However, when patients exhibiting some but not all of the diagnostic criteria are included, the lifetime prevalence for anorexia and bulimia nervosa are closer to 3.0-4.6% and 4.0-6.7% respectively (Wade et al. 2011). These numbers alone would be frightening, but making matters worse is the fact that patients with eating disorders have drastically elevated mortality rates; anorexia nervosa continues to have the highest mortality rate of any mental illness (Arceles et al. 2011; Räisänen and Hunt 2014).
A Gendered Paradigm

Since the debut of eating disorders in the field of psychiatry, eating disorders were, and to a certain extent still are, considered to be a female concern. Two of the earliest attempts to present a coherent “diagnosis” for anorexia nervosa, both published in 1973, one by William Gull and the other by Charles Lasègue, are based solely on vignettes and clinical case studies of young women and teenage girls. In addition, from its very first introduction to the American public, in an early article in *Science Digest* reporting on a “strange disease” afflicting adolescent girls, anorexia nervosa has been cast as a problem uniquely affecting teenage girls (Brumberg 1989). Furthermore, in *Fasting Girls: The History of Anorexia Nervosa*, Brumberg speaks of a fiction genre of “anorexia stories” intended to spread information about the disorder to the adolescent market, all of which feature an “attractive (usually 5 feet 5 inches), intelligent high school girl from a successful dual-career family” who “wishes to be slim because in American society slim is definitely a good thing for a female to be” (1989).

Thus, just as men were once assumed to be immune to the effects of media on shaping body ideals, they were also assumed to be immune to developing anorexia and bulimia nervosa (Raevuori et al. 2014; Räisänen and Hunt 2014; Strother et al. 2012; Sweeting et al. 2015). Clinical data sets, which include the studies referenced in the *DSM-5*, have traditionally indicated a highly skewed sex ratio of lifetime prevalences of anorexia and bulimia, usually reporting it to be about 1 in 10 patients, or 10% (*American Psychiatric Association* 2013; Raevuori et al. 2014). However, more recent epidemiological findings are now showing a ratio more akin to 1:3-1:4, suggesting a history of clinical underdetection (Hudson et al. 2007). As Eric Strother et al. described
it, eating disorders in men are “underdiagnosed, undertreated, and misunderstood” (2012).

At no point did I consider that I had an eating disorder. After all, as far as I was concerned, I was only doing what it seemed the fitness pros were doing. I remember thinking that I couldn’t possibly have anorexia or bulimia because I was still eating tons of food (or so I had convinced myself) and had never made myself throw up. The only examples of either disorder that I had ever heard of or seen photos of in the news or even in my school’s health class were skeletally thin women and supermodels. I genuinely thought that developing an eating disorder was something that could only happen to women and that to be anorexic one had to stop eating entirely. Furthermore, I couldn’t care less about my actual weight on the scale. I hadn’t even weighed myself once throughout this entire time. All I was concerned with was looking more athletic and lean – like the guys in the magazines and in the movies. Looking back, it’s no surprise that my behavior and thoughts slipped through the cracks of my extremely narrow perception of eating disorders.

The amount of underdetection seen with male eating disorders, though, is not at all surprising; the treatment and diagnostic paradigms surrounding eating disorders like anorexia nervosa have been so extensively gendered as female that it is to be expected, if not guaranteed (Raevuori et al. 2014; Räisänen and Hunt 2014; Strother et al. 2012; Sweeting et al. 2015). A significant milestone in the recognition of male eating disorders came in the form of the revisions made by the American Psychiatric Association in the
**Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5)** with regards to the diagnostic criteria for anorexia nervosa (Raevuori et al. 2014). As of the release of the DSM-5 in 2013, amenorrhea – the abnormal absence of menstruation – is no longer a diagnostic measure for the disorder and the wording of the weight criterion is much more lenient (American Psychiatric Association 2013). Though it was still possible for men to be diagnosed with anorexia nervosa, I would argue that the inclusion of amenorrhea in the diagnostic measures had a definite feminizing effect on the disorder in the clinical setting, especially when followed by the outdated 10:1 female: male sex-prevalence ratio (American Psychiatric Association 2013). In addition, authors of recent studies focusing on male eating disorders have found that current scoring ranges for the Eating Disorders Examination questionnaire – used in the clinical setting as a diagnostic tool to assess food-restriction, compensatory behaviors, and body image preoccupations – demonstrate little relevance for male patients, as the ranges have been derived from female patient samples (Raevuori et al. 2014). It has also been noted that professionals often overlook signs and symptoms in males that are indicative of an eating disorder because they do not always manifest in the same way they would in a female patient. For instance, it has been repeatedly found that men are less likely to engage in the “typical” bulimic compensatory behaviors of vomiting or laxative abuse, favoring excessive exercise for weight control following a food binge (Räisänen and Hunt 2014; Strother et al. 2012).

Upon my most recent visit to my old eating disorder clinic for a routine follow-up appointment, I was greeted at the registration counter with an advertisement for a new research study. The focus of the study was to investigate the effectiveness of an anti-
anxiety medication in bulimic patients experiencing nightmares stemming from trauma or abuse. Intrigued because of my studies in psychology and biology, I read further. The requirements for participation? Be between 18 and 45 years of age, and be female.

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It does not take much reflection to realize that this situation represents a decades-long cycle of positive feedback. Under the older versions of the DSM and traditional diagnostic models based on female eating disorder patients, the odds of a male patient receiving an eating disorder diagnosis, particularly for anorexia nervosa, were not favorable. As a result, disproportionately few men received diagnoses, translating into more clinical and epidemiological research that focus on females, further skewing the apparent gender distribution, and ultimately falsely reconfirming the notion that eating disorders chiefly affect women. It is only under the new DSM-5, which is believed to have a greater capacity to diagnose specific eating disorders in males, and with greater awareness on the part of clinicians that this cycle can hope to be broken and male eating disorders will emerge from the psychiatric niche to which they were previously relegated (Raevuori et al. 2014; Strother et al. 2012; Sweeting et al. 2015).

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A “cute lie” – that is how my male psychology professor referred to the argument that men represent a significant number of clinical cases of anorexia and bulimia nervosa.

That day in class, we were learning about eating disorders and body dysmorphic disorders. When we started on the topic, I had made a preemptive decision to avoid making any comments during the lecture because I did not want to assert myself as an
expert in the field by any means and, perhaps more, did not feel like expending that kind of mental energy in a class discussion.

We moved through body dysmorphic disorder without any problems, but when we got to anorexia and bulimia nervosa, it became harder to not say anything. While presenting the material, my professor consistently used female pronouns and phrases like “an anorexic girl” and “a teenage girl with bulimia.” Finally, sparing me from going against my decision, someone else in the class commented on his use of female pronouns, to which he responded that from a clinical perspective it was fine to just think of anorexia and bulimia nervosa patients as females. This is a college professor with undergraduate degrees and graduate degrees from some of the country’s top universities and many years of fellowship training and clinical experience under his belt. Furthermore, he went on to show the class a chart of clinical findings regarding male body image concerns that dated back to 1985, suggesting that the average man is perfectly content with his appearance and that it was only the female study participants that demonstrated dissatisfaction with their body image (Fallon and Rozin 1985). Though just a single incident, this is exactly the kind of gendering of eating disorders that plagues psychiatry and society at large. Not only did it show the persistence of the notion of eating disorders as exclusively a female concern in academia, but it was an instance of this gendered conception being conveyed to a class of students as a factual reality, thus allowing the misconception to endure.

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However, this heavily gendered paradigm surrounding eating disorders does not solely exist in the clinical setting. Societal perceptions and attitudes that body image problems and eating disorders were “women’s illnesses” have been circulating and
reinforced for decades (Pope et al. 2000; Räisänen and Hunt 2014; Strother et al. 2012). This is primarily due to the previous skews in the gender distributions of eating disorders, but I would also argue that these societal perceptions are also the result of the previously mentioned cultural biases that dictate that men should not concern themselves with their appearance (Bordo 1993; Pope et al. 2000; Strother et al. 2012). Regardless of cause, the result is an enormous social stigma surrounding male eating disorder patients that has implications for diagnosis, treatment, and recovery (Olivardia et al. 2004). Several studies have discovered that many men are unable to recognize their behaviors and symptoms as eating disorders because anorexia and bulimia nervosa have been so effectively constructed as a female concern by the scientific community and mass media (Pope et al. 2000; Räisänen and Hunt 2014; Strother et al. 2012). Many young men with eating disorders have also recounted an aversion to seeking help and treatment because of “not being taken seriously by healthcare providers” because they were men (Räisänen and Hunt 2014). Similarly, young men put off seeking help and receiving treatment because they do not see it as their place, as men, to appear emotionally vulnerable over their appearance and seek support. Scared of appearing feminine or gay, men also tend to not voice their body image concerns to friends and family (Pope et al. 2000; Räisänen and Hunt 2014; Strother et al. 2012). As Bordo wrote, “to be so passively dependent on the gaze of another person for one’s sense of self-worth is incompatible with being a man” (2000).

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I remained convinced of the impossibility that I had an eating disorder even when my parents took me to my primary doctor to check my weight and both they and the
doctor showed concern over my weight loss. According to the scale in the hall, I had dropped over twenty pounds, thoroughly confounding the once graceful arc of my growth chart. My mom and the doctor had a long conversation with me about eating more and exercising less. I believe there was also a threat disguised as comment that, if my weight didn’t start increasing soon, I might have to start seeing other doctors and maybe a psychiatrist. The only part of the entire consultation that I truly absorbed was that I hadn’t appeared to gain any muscle mass. So I agreed with my mom and the doctor, saying that my weight was probably too low and that I would try to put more weight on. In my head, however, this only meant trying harder to build a lean, muscular body.

I was given two weeks to get some weight back on. Needless to say, it didn’t happen. Shockingly, my revised diet that put even more emphasis on lean sources of protein in addition to a week of traveling that took me away from my normal, vetted, and safe snack foods and filled my days with lots of walking caused me to lose even more weight. I was now officially well below the “normal and healthy” BMI range for age group.

Something happened while I was away though – something that gave me pause and prompted me to wonder if something was actually wrong. Per the unspoken rules of family vacations, my mom insisted on taking photos of my brother and I on an almost daily basis. In these photos though, I didn’t like what I saw. I looked gaunt. I looked frail. I looked tired. I looked horrible. At first, I tried to shake it off, saying that it was probably because of the travel, but I couldn’t get past how terrible I looked. I had also begun to experience some symptoms beyond the mere weight loss. I found that it had become kind of painful to sit in the chairs at schools as I lost more and more body fat and
I had begun to bruise relatively easily. There was also a fainting incident at one of my tennis matches, which I tried to pass off as being due to the heat. It was then, finally aware of what was happening to me, that I told my parents that I would be willing to see some other doctors.

Those “other doctors” turned out to be an eating disorder clinic. The connections of my school’s guidance counselor and friends of my parents had gotten me into a treatment center at a local university hospital. I wasn’t sure what was going to happen for me there, as I was still under the impression that I couldn’t possibly have an actual eating disorder. I thought that maybe they had a nutritionist there who could give me a diet plan that could help me build muscle. But then, at some point during my meeting with the eating disorder specialist, after filling out a depression survey, after hearing again how low my weight had become, after hearing that my heart rate was disturbingly low, and after realizing that I had essentially become one of the rail thin patients I had seen in health class, it sank in. I broke down. I realized how tired I was of counting every calorie and obsessing over everything I ate. I realized that I wanted nothing more than to unlearn all of the calorie information I had memorized for almost every snack food and every menu item at the restaurants I went to. I realized that I had an eating disorder, despite what I had been convincing myself of for months, and that I needed help.

The unfortunate reality that receiving proper treatment or even a proper diagnosis presents a major hurdle for most men suffering from eating disorders is especially salient in the interviews with male anorexics sampled for this thesis. In the words of Nathaniel
Penn, after interviewing a host of male eating disorder patient for an article in *GQ*, a men’s fashion and lifestyle magazine: “diagnosis is hard. Finding treatment is even harder” (2012). Let us first consider the case of Steven, a 25 year-old former oil-field worker who had a brief stint in drug rehab. Steven fell into a vicious binge-purge cycle following his separation with a girlfriend who had also suffered from bulimia and then descended into a routine of detrimental calorie restriction. Steven was fortunate in that he received an initial burst of treatment while in drug rehab – he increased his caloric intake from 400 a day, to 800 a day, and then to 1,200 a day upon leaving rehab – but then was faced with the seemingly impossible task of finding a residential eating disorder clinic that would admit men. For him, it was incredibly dismaying, as he had had to work up so much courage just to open up about his disorder – “because it’s thought of as a girl’s disease” – and there was no help waiting on the other end (in Penn 2012).

This experience is also echoed in the interview of John, whose eating disorder began after graduating from law school when he crash-dieted and cycled his way to losing over a hundred pounds in eight months. With degrees in engineering and law and what was described as a truly photographic memory, John quickly became malnourished to the point where he was having severe cognitive difficulties and was let go from his job. As his anorexia became undeniable and his chronic overexercising got out of control, John began seeking treatment but found that, though he received explicit advice to enter a residential treatment center on account of his disorder, including his “state of mind, the hopelessness, [and] the inability to feed [himself],” he was repeatedly turned away from treatment on account of being male (Penn 2012).
John finally received treatment at a residential clinic in Missouri, but quickly relapsed upon returning to his life back in Los Angeles. He then had a brief stay at another treatment center, but was soon forced to move on after his insurance company no longer agreed to cover the expense. At the time of the interview, now 35 years-old, John admits to still harboring his eating disorder thoughts and beliefs, but has made great strides in his eating practices with support of his partner and the stability offered by a new job and is beginning to enjoy the semblance of a normal life.

The difficulty men face when seeking care for eating disorders is further illustrated dramatically by the extreme case of Will, a 21 year-old whose education was interrupted after the sixth grade. Weighing only 55-pounds when he was admitted to The Acute Center in Denver, CO, Will had been battling an eating disorder for half of his life and bore the voice of a man who had never gone through puberty and the soft peachy hair all over his body – lanugo – that is the hallmark of a severe anorexic (Penn 2012). Similar to many anorexics, Will’s disordered thinking and eating practices began as a coping mechanism for insecurities and feelings of worthlessness. Despite the growing severity of his condition, however, Will recounted that “getting help at that young of an age and being a male was like shooting in the dark and expecting to get a bull’s-eye” (in Penn 2012).

Even when he did manage to find clinics that would admit him, Will complained that he was the only male patient and that a bulk of the material that was being covered in the treatment groups was geared toward female patients (in Penn 2012). This experience was shared with Jonathan, also a teenage male who began bingeing and purging at the early age of 11 years-old and, though fortunate enough to gain admittance to an eating
disorder clinic, found himself the only male patient there and only with access to treatments aimed at body image and internal mental battles that did not apply to him (Chatterjee 2013).

As these clinical studies and interviews with actual patients demonstrate, men suffer from eating disorders differently than women. In some ways, I would go as far as to argue that its the men who suffer more acutely. It has now become more socially permissible for women to recognize and vocalize their body image concerns, react openly to unrealistic expectations and ideals, and have more access to support and recovery resources. However, as exhibited by these interviews and studies, men are clearly still restricted by the socially determined confines of masculinity and cultural taboos that prevent them from voicing such concerns, allowing their anxieties and preoccupations to fester inside (Pope et al. 2000). This is not to make the claim that women do not also suffer stigmatization related to eating disorders or that in today’s women are able to freely voice their body image concerns, because this is most certainly not the case. Instead, I am trying to iterate the fact that men with eating disorders, in addition to facing the social stigmatization related to eating disorders, must grapple with what seems like a challenge to identity as male. Furthermore, with In the chilling words of the GQ article interviewing male anorexics, a key difference separating male and female anorexics is that, for the overwhelming majority of men, “help is not on the way” (Penn 2012). The unfortunate result of this is that recent studies have suggested an increase in psychiatric morbidity from eating disorders in male patients, relative to females (Räisänen and Hunt 2014).
After that first meeting at the eating disorder clinic, I was supposed to compete in the last tennis match of the season. However, the doctor had advised against it, officially barring me from any form of exercise. I called my coach, saying that I couldn’t play because I was sick but that I would still come and support my teammates. I vividly remember sitting there at the match, not on the team bench or in my uniform, just by myself in the bleachers. All I had wanted was to look more like an athlete and feel like I belonged more with the other guys on my soccer and tennis teams – the guys to whom it didn’t matter if they were on “skins” or “shirts” and who ate whatever they wanted – but there I was, on the bleachers, feeling weak and tired.

Muscle Dysmorphia

The revision of the diagnostic criteria for anorexia nervosa in the DSM-5 was an undeniable advance in the recognition of male eating disorders, but another significant milestone came in the form of the inclusion of muscle dysmorphia as a subtype of body dysmorphic disorder, “characterized by the belief that one’s body build is too small or is insufficiently muscular” (American Psychiatric Association 2013; Raevuori et al. 2014). Individuals with muscle dysmorphia – predominantly men – obsess over their physique, perpetually seeing themselves as too small and too frail and compulsively trying to achieve the lean, muscular ideal permeating mass media. In other words, they aspire to get the most muscular bodies with as low percentage of body fat as possible (Grieve 2007; Pope et al. 2000).
If this diagnostic description doesn’t sound familiar, it should; there is a
tremendous amount of overlap between the diagnostic criteria for muscle dysmorphia and
both anorexia and bulimia nervosa. Behaviorally speaking, all three disorders feature
similar changes in eating and exercise practices along with distorted body perception. In
fact, the original conceptualization of muscle dysmorphia in the psychiatric community
was “reverse anorexia” owing to the number of similarities to traditional views of
anorexia except with a different social ideal. Even more colloquially, muscle dysmorphia
has been coined “bigorexia nervosa” (Grieve 2007; Pope et al. 2000).

It is worth noting, however, that muscle dysmorphia, though strongly echoing
anorexia nervosa and bulimia nervosa, was not included in the DSM-5’s section on eating
disorders. Furthermore, muscle dysmorphia, from its conception, has been almost
ubiquitously gendered as a male concern (Grieve 2007). One interpretation of this
categorization could be that there is an unconscious bias within the medical community
that eating disorders are a female concern. Such a bias would potentially explain the
preliminary labels given to this “new” disorder (Grieve 2007; Pope et al. 2000). To this
end, the introduction of “muscle dysmorphia” as a diagnostic category distinct from other
eating disorders could be indicative of the fact that anorexia and bulimia have become so
tightly linked to the feminine ideal of size zero supermodel that when men began
presenting to clinicians with the same behaviors and symptoms but with the desire to
become bigger and more muscular, medical professionals thought it warranted the
creation of a new diagnosis. It would undoubtedly sound more masculine or appropriate
for a male patient to essentially be diagnosed with a preoccupation for getting bigger and
more archetypally masculine (Bordo 1999). At the core, however, it is essential to
remember that both male and female eating disorder sufferers are driven by the consuming desire to produce different bodies.
Isn’t definition the male equivalent of anorexia? The need for control driven to the verge of suicide

(Lynn Luciano 2001)

Chapter 4: “Stylized Acts”

Gendering of Behavior

The study of how bodies and bodily actions come to signify a particular gender goes back to the canonical work of Judith Butler, who argues that gender, far from being static, is a fluid identity established through a “stylized repetition of acts” and the “stylization of the body” (1990). What Butler identifies as “stylized acts” and the “stylization of the body” can be thought of as gender displays, or the ways in which individuals demonstrate that they align with the ideals of masculinity and femininity. To Butler, the performative body serves as a vehicle for gendered subjectivity to come into being and underlying each and every gender performance is the wish to project a coherent and convincing identity that is both recognized and validated by society (Alexander 2003; Butler 1990; Tyler and Cohen 2010).

This idea of the creation of gender identities and the “stylization of the body” is echoed in the theoretical work of sociologist Raewyn Connell, who argues that gender differences are founded on the negation of bodily similarities and an exaggeration of bodily differences (Butler 1990; Connell 1987; Shilling 2012). An instance of such a negation of biological similarities is when young girls are branded as weak and fragile, despite the fact that generalization is far from universal. Similarly, in her historical narrative on the relationship between culture and sexuality, Ludmilla Jordanova argues that conceptions of gender constructed by society often seek to be grounded in the materiality of the body, leading members of society to create “natural facts” rooted in the
presentation of the body (1980). Thus, these conceptions of categorical biological differences are integral to the creation of social categories that differentiate men and women and in turn give rise to practices of body transformation that attempt to exaggerate these corporeal differences (Shilling 2012).

When it comes to the “stylized acts” associated with being male and the socially recognized masculine identity, however, there is no reference to “beauty work” (Alexander 2003; Bordo 1999; Luciano 2001). Pervasive in the literature focusing on the symbolism of the body and processes of body beautification and management is the notion that dieting and making the body beautiful has been unquestionably gendered as feminine (Bordo 1993; Reischer and Koo 2004; Stearns 1997). This notion stems from the equally pervasive mentality that it is not a man’s place to focus on his appearance or speak openly about any body image concerns he may have; that is women’s work (Alexander 2003; Bordo 1999; Luciano 2001; Pope et al. 2000). According to historian and philosopher Elisabeth Badinter, “to be a man” in the twenty-first century entails first and foremost “no sissy stuff,” an umbrella under which Western society has clearly placed “beauty work” (Luciano 2001).

To align with the hegemonic masculine ideal, a man must be competitive, constantly demonstrating his success and superiority, he must remain detached and impassive, leaving any “hysteries” to women and appearing emotionally invulnerable, and he must be willing to take risks and confront danger (Alexander 2003; Luciano 2001). Furthermore, a “real man” in society must never resemble a woman or display any exceedingly feminine characteristics, such as using cosmetics or paying excessive attention to clothes or hygiene (Alexander 2003). As Sven Lindqvist wrote in Bench
Press, exploring the world of male bodybuilding, “a man [is] permitted to be beautiful if nature had made him that way... but he mustn’t exert himself to become so, because that would mean he was vain and open to ridicule” (2003). In other words, the notion of making oneself beautiful has become culturally synonymous with the making oneself more feminine.

**Bodybuilding**

In terms of gender displays and the social symbolism inscribed on the human body, bodybuilding presents an interesting example. As has been brought up several times in this thesis, a lean and muscled body has traditionally and continues to symbolize masculinity, power, and dominance in our society (Alexander 2003; Luciano 2001). The hulking muscles of bodybuilders, then, would logically be considered the hallmarks of an alpha male. Indeed, just as the term “eating disorder” typically brings to mind an image of a teenage girl, the term “bodybuilder” brings to mind an aspiring Arnold Schwarzenegger bursting through his tank top. On this note, it is worthwhile to point out that, in his book on bodybuilding, Lindqvist uses only the male pronouns throughout when describing the bodybuilder (Lindqvist 2003). However, you can be sure that serious bodybuilders are not spending all that time in the gym simply to build their moral character or for the merits of activity alone.

Bodybuilding is all about getting as big and lean as possible and then competing in pageant-like competitions that include endless flexing and posing in order to highlight the rippled muscle striations that took literal blood, sweat, and tears to achieve. The lifting itself is in many ways just a means to an end – what matters to bodybuilders is the resulting aesthetics. Even those that never actually compete are likely to spend hours
flexing in front of the mirror and showing off their hard earned muscle definition to fellow gym-goers (Lindqvist 2003). Put differently, these men are slaving away on their appearance and then putting their bodies on display and attaching their self-worth to the approving gazes of an audience and perhaps a handful of judges. Thus, while muscles are symbolic of masculinity, the sport of bodybuilding, with its intense focus on self-display and appearance, has a number of aspects that are decidedly gendered as female, such as posing, extreme diets, and “beauty work” (Bordo 1999; Luciano 2001).

This interesting paradox at the heart of bodybuilding, however, is only part of its relevance to this thesis. Bodybuilders meticulously plan out what they eat, often cutting down to the absolute minimum number of fat and carbohydrates, and work out for multiple hours every day in order to simultaneously have spectacularly high muscle masses and spectacularly low body fat. In bodybuilding parlance, this is referred to as “defining,” or cutting back on caloric intake while increasing caloric expenditure in order to get rid of any subcutaneous fat and allow individual muscles to stand out (Lindqvist 2003). This type of behavior should immediately bring to mind the self-destructive aspirations of the typical anorexia patient – increase exercise and decrease caloric intake in order to achieve the perfect body – but, when a bodybuilder or even just an amateur gym enthusiast does it, it is merely viewed as part of the sport. In his book attempting to intellectualize bodybuilding, Lindqvist himself even makes the connection, asking if definition isn’t just the male equivalent of anorexia (2003). Bordo also makes note of this similarity in Unbearable Weight, arguing that “dictation to nature of one’s own chosen design for the body is the central goal for the body-builder, as it is for the anorectic” (1993).
Society in general, however, often fails to make the connection. Perhaps it is because bodybuilding is associated with activity, which is traditionally considered a male domain, or because the social ideals are different, causing the symptomology to present differently (Grieve 2007; Luciano 2001). In her book on male body image, Luciano argues that men are able to carry off the extreme behaviors characterizing an eating disorder – crash dieting, long hours at the gym, supplementation, etc. – on account of cultural preconceptions what eating disorders are supposed to look like and what constitute “healthy male activities” (2001). Similarly, in her study of Men’s Health magazines, Susan Alexander recounts a special feature titled “How to Become a Greek God,” commenting on how if the same article had been published with women as the intended audience, there would undoubtedly be criticism (2003). However, because men were the focus and the diet and exercise was aimed at gaining more muscle, there was probably no consideration that it could be triggering eating disorders or distorted body perception (Alexander 2003). A man with the consuming desire to become more “godlike” and muscular no matter the cost in our society is not viewed as symptomatic of an eating disorder or having body image problems – it is simply being manly.

Take, for instance, a friend group of teenage boys who constantly compete with each other to get bigger muscles, lift heavier weights, and achieve a more defined six-pack. With these objectives in mind, the boys spend hours at the gym every day, consume a variety of protein and athletic supplements, and switch to a high protein, low calorie, carb-cycling diet. They would probably be seen as slightly excessive, but I bet that no one would make the mental leap to suspect them of eating disorders. Instead, there is a decent chance that they, like I was, would be lauded for their efforts and
dedication. Even if all of this was also accompanied by the group of boys beginning to avoid social outings, becoming extremely inflexible in relation to their food and workout schedule, and markedly thinner, I would still speculate that no one would guess that these boys were suffering from an eating disorder.

Now imagine a friend group of adolescent girls who constantly compete with each other to get the “perfect” bikini body, who spend a comparable amount of time at the gym, also start consuming supplements promising weight-loss, and switch to an extreme low calorie, high-protein, low-carb diet. The teenage girls are probably going to be suspected of eating disorders much more readily than they’ll be receiving praise for their dedication.

This is not to say that all bodybuilders should begin treatment at an eating disorder clinic; rather, I am choosing to include a discussion on the sport of bodybuilding because it demonstrates how symptoms and behaviors that would potentially trigger suspicions of an eating disorder in women often are able to escape notice in men. In fact, constricting the discussion to actual bodybuilders is quite unnecessary; the intense pursuit of “definition” is observable in the general male populace. Surveys have shown that a significant proportion of the male population use exercise to try to change the way they look and, professional competitor or not, there is a growing emphasis on competition among young men in their peer groups to be big, muscular, and fit (Grogan 2002). Furthermore, the *Men’s Health* article discussed previously in this chapter, “How to Become a Greek God,” was not necessarily aimed at bodybuilders; it was primarily aimed at the average man (Alexander 2003). As was discussed earlier in this thesis, this kind of exposure to impossibly lean, toned male physiques, especially among young men
and boys, is not to be underestimated (Alexander 2003; Bordo 1999; Mealey 1997; Nichter and Nichter 1991; Olivardia et al. 2004; Pope et al. 2000; Strother et al. 2012).

Thus began the three-pronged treatment plan that had been hashed out by my parents and the doctors during that first consultation. For medical appointments, I would continue to see the director of the clinic because she was the most familiar with my case. Every week I would meet with her to have my weight and vitals checked and have my physical health monitored. Following this appointment every week, I would meet with a psychiatrist for an hour-long session to help me work through my body-image concerns, my desire for control, my anxieties, my perfectionism, and my depression. Finally, I would meet with a nutritionist every week to break down what I was eating every day and steadily increase my daily intake to help me gain weight back until I was at a healthy body-mass index.

It is important to note that my treatment plan was not standard. I did not know it at the time, but when I arrived at the clinic for that first consultation, my dramatic change in weight, extremely depressed and anxious state, and slowed heart rate qualified me for the clinic’s day program, in which patients take a leave of absence from their schools and receive the equivalent of homeschooling at the clinic while also being monitored and receiving eating disorder treatment. This is the closest thing my clinic had to a true inpatient program, which is the standard treatment for extreme cases. In what turned out to be a stroke of good fortune for my recovery, however, the director of the clinic and my parents opted to create an outpatient program for me instead.
From what I learned later, the doctors and my parents decided that being admitted to the day program would hinder more than help my recovery. For one, the director of the clinic feared that it would be too demoralizing for me to be grouped with the other day program patients, many of whom were younger and all of whom were girls. I imagine the director was worried my presence would both cause my depression and anxiety to intensify and perhaps have a negative effect on the recovery of the other patients, who would be less likely to open up about body image concerns with a teenage boy in the room. In addition, the director's knowledge of my background, my personality, and more or less my current life at school led her to the conclusion that I was an independent, driven person who would not benefit from being under constant instruction and observation. She also probably believed that pulling me out of school and potentially jeopardizing my academic future would have put me over the edge. For all of these reasons, my treatment team and my parents took a gamble on me and my recovery, deciding to at least start with an individualized outpatient treatment plan.

Perhaps the aspect in which my treatment differed the most from the other patients was my nutritional consultations. Nutrition plans, after all, are much easier to devise and modify as necessary if the patients eat most of their snacks and two of their three meals at the clinic itself; days spent at the clinic left no ambiguity in terms of caloric intake and, perhaps more importantly in some cases, no chance for compensatory behaviors after eating. Furthermore, the nutritionist who made up part of my treatment team and with whom I met for the first four years of treatment had very little experience with male patients and had no template diet plans or firm caloric targets for me to follow. As a result, the nutritional aspect of my outpatient treatment plan was almost
completely customized; I would receive approximate guidelines for portion sizes and caloric requirements, my parents would be informed and given loose descriptions of what and how much I should be eating. I would keep track of everything I ate in between appointments, and then, depending on what my weight had done that week and the amount of GI distress I had encountered, me and the nutritionist would tweak my diet accordingly.

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These first few weeks were probably some of the mentally hardest weeks in my life. Though I had started treatment, my thoughts of restriction and obsession were clearly still there and louder than ever. Eating all of the extra food and calories was making me insane, and I was no longer allowed to exercise. My customized meal plan more or less became instructions to have four meals a day and a bowl of ice cream every night until my weight got back up. On top of this, I had to start every day with a calorie-dense nutritional shake intended for toddlers and geriatric patients who have trouble maintaining their weights. All of this extra food was physically uncomfortable – my digestive system had some catching up to do – but even more uncomfortable were the feelings and anxiety I suffered following every meal and snack. My worry that all of these extra calories would rapidly become fat was almost debilitating and every day that I went without exercise made me fear that the muscle mass that I had somehow managed to cling to was slowly turning into fat and loose skin. Of course, these fears and worries were dramatically incorrect – it actually took almost a month of eating like this before I was able to gain any weight – but they were so intense in my head that many times I was brought to tears. As a result, once I was finished with classes for the year, my treatment
team decided that I would benefit from ramping up my meetings with my psychiatrist to twice a week.

To my shame, even though I had been given the privilege of the autonomy that went along with an outpatient treatment plan, I was far from the perfect patient. I schemed ways to convince my doctors and parents that some of my habits were for reasons other than my eating disorder and that some of my eating behaviors were examples of my “progress,” when in fact they were just modified eating disorder behaviors. I remember trying to sneak in some illicit exercise every so often, such as walking around the neighborhood a couple times on my way home from school or doing ab exercises in secret in my room when my parents thought I was changing or studying. I particularly remember one instance when, instead of opting for a cab or the subway as any sane person would have done, I dragged my brother and a friend along on an onerous walk from Columbia University to the Modern Museum of Art in New York City – about 63 city blocks – in the middle of July.

Fortunately, as a teenage boy, I was spared from offering explanations when my treatment plan required me to suddenly start consuming large amounts of high-calorie food that was relatively lacking in nutritional value. No one gave the teenage boy eating an entire pizza or an entire bag of trail mix a second glance. Waiters and waitresses wouldn’t even bat an eyelash. Ironically, it turned out that not only does it escape people’s notice when a teenage boy starts eating less, but similarly little attention or concern is elicited when he starts eating dramatically more.

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Over time, I managed to regain some weight and get back to a healthy BMI range. It took most of the summer and it was not until the start of the next school year that I was allowed to start exercising again. My treatment team and parents thought that I would benefit from exercising “as a normal high school boy” by going out for soccer again. However, given my precarious position at the very periphery of the healthy BMI range and the statistically high chance of me relapsing, it wasn’t until the winter that I was allowed to stop drinking the high-calorie nutrition shakes or to stop recording everything I ate to show my nutritionist. The restrictive thoughts and eating-induced anxiety continued for longer than probably even my treatment team realized, but even these too got better with time, or least more manageable.

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Though I recovered from my eating disorder by the end of high school, nearly four years ago, I still have to routinely visit my clinic for monitoring because the relapse rate for anorexia nervosa is high. That makes it almost six years that I have been going to the same clinic. At the beginning, I had three weekly appointments. Going into my junior year of high school, the appointments became monthly and then bi-monthly for the remainder of my time at home. Upon going to college, it was decided that I would only have to come in for checkups when I was home on break. Why am I recounting a long winded account of the frequencies and time courses of my visits to the eating disorder clinic? Because, throughout these six years of weekly, monthly, and semiannual appointments, I have never seen another male patient.

When I started going to the clinic, my presence in the waiting room and walking through the hallways of consultation rooms was always met with surprise and confusion,
both from the parents of other patients and the other patients themselves. As my condition started to improve and I began to regain some weight, it was not uncommon for me to be assumed to be the brother or boyfriend of a patient. On more than one occasion, I was asked if I was lost or if I had meant to go to the endoscopy center on the floor below.

Compounding all of this, the atmosphere of the clinic had an undeniable “haven for teenage girls” vibe. For instance, as a healing exercise, the in-patient group who came to the clinic rather than normal school had emblazoned all of the chairs in the patient-consulting rooms with Taylor Swift lyrics. Most of the rooms had flower and butterfly decorations, and the hallways often had collages and murals plastered with inspirational quotes regarding dress sizes along with photos from beauty magazines.

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*Gendered Spaces*

Though this thesis is focused mostly on bodies and the gendering of bodily practices, I feel that I must make a brief tangent into the gendering of spaces and the resulting effects on eating disorder treatment. In her *Gender Trouble*, Butler herself makes reference to the “materialization of gender in space” and how gender comes to be “instituted in an exterior space” (1990). This was then extended in a recent study by Tyler and Cohen, studying how the performative gender norms introduced by Butler are manifested in the gendered creation of certain spaces (2010). Coming to the conclusion that space, much like the body, is an intentionally organized materiality with respect to the performance of gender, Tyler and Cohen make it clear that gender norms are enacted throughout organizational spaces (2010).
This kind of intentional organization is exactly what had happened at the eating disorder clinic, and understandably so. Given that the vast majority of the clinic’s patients are teenage girls, it only makes sense that the clinic would want to try their hardest to create what feels like a safe space for girls to be themselves and express their feelings. However, an unintentional consequence of gendering the treatment facility as female was the alienation of any men with eating disorders seeking treatment. Thus, the gendering of eating disorder treatment facilities as female can be detrimental to the recovery of male patients. Speaking for myself, it was hard to not occasionally feel as if I was out of place. I didn’t share the experiences that were plastered on the walls and I couldn’t relate to the song lyrics emblazoning the chairs. Further, from interviews and memoirs of male anorexics, I know that I’m not alone in this feeling of not belonging (Chatterjee 2013; Penn 2012).
Looking good is part of a quintessential male strategy whose ultimate aim is to make men more successful, competitive, and powerful. The means of achieving this goal may be new, but the objective is not

(Lynn Luciano 2001)

Conclusion:

By the end of high school, I had recovered from my eating disorder. My customized treatment plan had been a success; my weight was back to normal, my anorexic and body dysmorphic thoughts had attenuated, and the anxiety and depression were gone. This was a difficult time of my life and at times was mentally and physically brutal, but my recovery is probably one of my greatest accomplishments and I am proud to be one of my doctors’ success stories. To my treatment team, I am eternally grateful. Less than half of eating disorder patients ever manage to recover – the rate is speculated to be even lower in male patients – and studies have found that around 35% of patients will relapse (Carter et al. 2004; Räisänen and Hunt 2014; Steinhausen 2008). I was lucky. A combination of social capital, good medical insurance, the luck of having a treatment clinic relatively nearby, and family support helped me get around many of the typical barriers to treatment. It was through family and school connections that I was admitted to the clinic in such a timely manner, it was thanks to my parents’ support that I was able to attend and afford three medical appointments a week for months on end, it was thanks to my social support networks that I was able to open up about what I was going through instead of letting my feelings go unvocalized in my head like the majority of male anorexics, and it was because of my treatment team’s faith in me and customized plan for me that I was ultimately able to get better.

Unlike most men suffering from an eating disorder, I had people rooting for me every step of the way (Pope et al. 2000). Furthermore, because of my treatment
resources, my education was disrupted as minimally as possible, and, unlike most of the other teenage patients who attended my clinic, I didn’t fall behind in school. I finished my senior year on time, as valedictorian of my graduating class, and with an acceptance to one of the best colleges in the country. When I look back on the past seven years or so of my life, I am alarmed by how differently everything could have gone. It is not rare for an eating disorder to completely derail someone’s life, especially in the case of men who have additional barriers to receiving a diagnosis or treatment (Olivardia et al. 2004; Penn 2012). What if no one had recognized what was wrong with me until it was too late to recover as fully as I did? As a teenage boy, having my symptoms recognized so early and being diagnosed at all could be aptly described as a miracle (Räisänen and Hunt 2014). What if the only treatment option presented to me would have taken me out of school? If my condition had progressed any further, this is most likely to have been my only option. What if I hadn’t been presented with any treatment option at all? As demonstrated by the interviews and memoirs of other male anorexics, this is an exceedingly common dead-end on the path to recovery (Chatterjee 2013; Penn 2012).

Power of the Established Discourse

Eating disorders, particularly anorexia and bulimia nervosa, have been gendered as female in psychiatric and societal discourse. The significance of establishing this gendered discourse is not to be ignored, as is demonstrated in the anthropological work of Emily Martin. Focusing on the scientific language used to describe the biological processes of reproduction and menopause, Martin discusses how the perpetuated scientific depiction of the egg and the sperm encapsulate cultural archetypes of femininity
and masculinity. The egg is viewed as passive and dependent on the actions of the sperm, while the sperm itself is depicted as agile, active, and forceful. To Martin, this is a clear case of the "facts" of biology being constructed in cultural terms (1991).

Martin argues that the establishment of such a gendered discourse has the effect of seeming to naturalize our social conventions about gender. However, whereas Martin stresses that the medical and scientific discourse surrounding reproduction and cellular mechanisms is articulated at the expense of women, I am claiming that the reverse is happening in the context of eating disorders and body image concerns – these discourses have been crafted at the expense of men. Just as how the implanting of cultural gender stereotypes on the biology of reproduction has affected how menstruation is thought of, the discourse on the femininity of eating disorders has colored the way in which society and clinicians conceptualize them.

The female-gendered discourse surrounding eating disorders and body image concerns has shaped decades worth of clinical studies, psychiatric data, treatment plans, and healthcare and medical education (Hudson et al. 2007; Raevuori et al. 2014; Strother et al. 2012; Sweeting et al. 2015). In addition, just as Martin suggests is the case with scientific accounts of reproduction, the cultural aspects embedded within descriptions of eating disorders appear to be solidly entrenched and have gone on to influence new work in the field. For an example, one must look no further than the introduction of muscle dysmorphia. Rather than challenging the stubborn notion of anorexia nervosa patient being a teenage girl wasting away to skin and bones, a separate discourse was established so as to be applied to muscular men presenting to clinicians with eating disorder symptoms.
Moving Forward

The widespread belief that men are not subject to media pressures for the perfect body is as outdated and blatantly incorrect as the belief that men are not at risk for developing an eating disorder. Needed now is a greater understanding and social cognizance of the cultural pressures that men face for a particular body shape and size and of the growing prevalence of male eating disorders. One way to achieve this would be a greater wealth of empirical data sets that encompass male as well as female patients so as to produce more effective and less skewed diagnostic criteria, physical and mental assessment tools, and, perhaps most significantly, treatment models. As has been noted and exceedingly demonstrated, current diagnostic and treatment paradigms are leaving far too many men behind and there are far too few resources available for men to use for support (Raevuori et al. 2014; Strother et al. 2012). Another way is to change and gender-neutralize the popular discourse around body image and eating disorders, which currently only seem to paint the picture of a waif-like young woman. As it is now, the current discourse does not allow men to be open about their food and body issues, despite the fact that they are under enormous pressure to achieve the ideal muscular, toned male body. The cultural paradigm for the understanding of eating disorders ushered in by Bordo, Chernin, Orbach and Boskind-White must now be broadened to encompass men (Bordo 1993). Furthermore, the story of the male anorexic must be brought into the open. Owing to the underrecognition of and social taboo associated with male eating disorders, there is unfortunately not a wealth of autobiographical narratives depicting the lived experience of men with eating disorders. By incorporating my personal experiences
as a male eating disorder patient, my main intention was admittedly to bridge the scholar-patient divide, following the precedent set by Mukai (1985) and, to a certain extent, Lindqvist (2000). However, in addition to spanning the scholar-patient gap, the interweaving of my lived experiences throughout this thesis was intended to help fill the void of male narratives in the eating disorder literature. It is my hope that this dialogue continues and that eating disorders and body image concerns in men are given their warranted attention going forward.

*Adding Men to the Discourse*

By incorporating men into the discourse surrounding eating disorders and body image concerns, we stand to gain more than just increasing treatment for and recognition of male eating disorder patients. Beyond recognizing the problem of male eating disorders, I argue that the reshaping of this discourse would be an impetus for a different way of understanding gender distinction and how the patriarchy is operating. As the social and medical discourse surrounding eating disorders and body image concerns stands now, women are being cast as image-obsessed and self-manipulative for the sake of appearance. The patriarchy has established a system of meanings and values that has both built on the biological differences between men and women, and negated the importance of the male body in how gender is constituted. Furthermore, this system of meanings is echoed in modern-day capitalism, which, though media and the marketing of goods, has constructed the notion of the female body as a project and something to be worked on. Men should be strong, fit and well kept, but they should not exercise for vanity of dwell on appearance, whereas women must maintain their bodies in a particular way in line with how the patriarchy has constructed our notions of gender. By claiming
that only women develop eating disorders, we are reaffirming the notion that, for women, appearance is what matters. By extension, we are saying that, for women, appearance is the main currency of prestige. However, the patriarchy has fundamentally placed both the male and the female body under the public gaze and, driven by capitalist consumer culture, the male body has also come to be seen as a site for control and maintenance work. If the conceptualization of eating disorders and body image concerns were adapted to include men, we would be reconstructing these cultural notions to show that, for everyone, bodily appearance is both a source of concern and a source of prestige.
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