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Body Dissatisfaction in Adult Men

Gillian Adams

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Thesis Abstract

Historically, the phenomenon of body dissatisfaction (BD) has received most attention within the field of eating disorders, and has often been investigated in female samples. There is growing recognition, however, of the importance of BD to men. The purpose of the review paper was to examine this literature base. Attention is given to the nature and prevalence of BD in men, as well as its influences and sequelae. Much of the current research remains limited by its reliance on inappropriate assessment tools. Development of a new measure is highlighted as a necessary prerequisite to further research in this area. In view of the limitations of existing tools, a qualitative approach was utilised in the empirical paper, to explore the phenomenon of BD in men. Semi-structured interviews were conducted with a purposive sample of men (N = 14), with the intention that analysis of interview data would form the first phase in the development of a valid assessment tool. Analysis yielded 15 themes across 4 domains (societal, interpersonal, intrapersonal and social presentation). Themes focused broadly on the influences on BD, and the way in which these are managed, rather than on specific foci of concern. It is proposed that these generic issues would form a more helpful basis for a new assessment tool, than would an inventory of particular appearance concerns. Findings are related to existing theories, and whilst the study's limitations are acknowledged, possible implications for practice are discussed.

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Body Dissatisfaction in Men: A Review of the Literature

Gillian Adams*

School of Psychology, University of Southampton

* Address for Correspondence: School of Psychology, Doctoral Programme in Clinical Psychology, University of Southampton, Highfield, Southampton, SO17 1BJ, United Kingdom.

Tel.: +44(0)23 80595321; fax: +44 (0)23 8059 2588.

Email: gca201@soton.ac.uk

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Abstract

In the past body dissatisfaction (BD) has often been considered in relation to eating disorders and examined in predominantly female groups. More recently attention has turned to the occurrence of BD in men. This review aimed to examine and critically evaluate the literature relating to men. Current research regarding male BD is commonly constrained by limitations in existing assessment tools. In spite of this, a number of issues are raised. It is argued that the prevalence of BD may be increasing amongst men. Sociocultural factors are implicated in the development of BD in men, but are unlikely to be exclusive. Understanding of these and of other influences remains incomplete. The behavioural outcome of BD for men is reviewed and the relation of BD to a range of negative sequelae is highlighted. It is argued that development of a valid assessment tool is necessary to enable further exploration in this field.

Keywords: Body dissatisfaction; Men

Introduction

Whilst there has been considerable interest in the field of body image, the majority of research has focused on one aspect of the construct; namely body dissatisfaction (BD). Within this, research has most often considered the relationship of BD to the eating disorders and has commonly examined the phenomenon in predominantly female samples (Cash, 2004). It is the intention of this paper to provide a detailed overview of the more specific research evidence in relation to BD in men. The discussion will touch on those aspects of the research with women that are pertinent to this.

The paper begins with a brief review of the conceptual development of the body image construct and considers how the more specific phenomenon of BD relates to this. Attention is then given to theories of BD. This introductory review is not intended to be exhaustive but, rather, aims to frame discussion about the more specific research with men within its wider theoretical context. The paper goes on to make a more detailed examination of the extant research regarding BD in men. Attention is given first to the nature of BD in men and its development over time. Research evidence concerning groups of males who may be at particular risk for BD is then discussed and the possible contributors to, and outcome of this risk reviewed. The review focuses on the clinical significance of such body image research with reference to its relationship to different disorders in men. Attention is given throughout to the applicability of existing measures of BD to male groups and inadequacies in the existing research are highlighted.

Body Image: Overview of Concepts and Theory

Conceptual Development

Understanding of the term "body image" has evolved, varying both over time and according to the theoretical perspective from which the construct has been applied. The earliest conceptualisations of body image are commonly traced back (see Cash, 2004; Fisher, 1990; Fisher & Cleveland, 1958 for reviews) to research in neurology and, specifically, to the distorted bodily perceptions experienced by individuals with various neuropathologies. Early constructions of body image as a perceptual or neural mechanism, such as Head's body "schema" or "postural model of ourselves" (Head, 1926, p. 605) were developed in efforts to understand such clinical phenomena as the "phantom limb". The continued broadening from this physiological or perceptual focus over time is seen in Schilder's comments: "We do not act merely as a perceptual apparatus. There is always a personality that experiences the perception" (Schilder, 1950, p. 15). The founding of body image as a psychological concept is further evidenced in research considering the possible psychological aetiologies of the body image distortions common to certain psychopathologies such as depersonalisation, conversion and schizophrenia (e.g. Schilder, 1950) as well as the frequent inclusion of bodily foci within psychoanalytic theory (Fisher, 1990). Whilst much recent research within the field of body image has been concerned with bodily appearance, this emphasis on the physical appearance of the body is, therefore, most accurately nested within a

broader conceptual framework incorporating wider bodily experience and functions (e.g. Shontz, 1974). In recognition of the wider aspects of body image, Cash (2004) notes that body image refers "especially but not exclusively [to] one's physical appearance" (p. 1).

Current Conceptualisations

Skrzypek, Wehmeier, and Remschmidt (2001) note that body image remains poorly defined. However, in keeping with Slade (1994) they acknowledge a general consensus that the construct consists of two components: one's thoughts and feelings about the body (attitudinal) and estimation of one's body size (perceptual). Accordingly, Skrzypek et al. argue that body image dysfunction can exist within each of these modalities; as a perceptual distortion or as attitudinal dissatisfaction. This distinction is supported to some extent by research. For example, with specific reference to patients with anorexia nervosa, Garner and Garfinkel (1981) noted that body image disturbance may be manifest as a perceptual inaccuracy in size estimation and/or a negative cognitive-affective evaluation. As satisfaction is essentially a cognitive-evaluative construct, body *dis*satisfaction refers most accurately to dysfunction within the attitudinal domain. There is some debate in the literature, however, regarding whether the attitudinal and perceptual dimensions described are truly independent. In a review of selected body size estimation research Slade (1994), for example, notes that the degree of distortion shown by eating disordered participants in their estimates of size

has varied according to whether such judgments were made on a cognitive or affective basis.

Although its independence from the perceptual dimension thus remains subject to debate, attitudinal BD will be the focus of remaining discussion for the following reason: whilst perceptual distortion, given its typical reference to body size may be viewed as a somewhat limited index of dysfunction regarding body shape or weight specifically, attitudinal indices of body (dis)satisfaction may both include and extend beyond parameters of shape and weight and thus have a wider applicability to the construct of body image per se.

Whilst there is general agreement within the research regarding the actuality of a non-perceptual or attitudinal dimension to body image (e.g. Skrzypek et al., 2001), the proposed content of this construct has varied according to individual theory. Thompson (1990) delineates three components to body image: alongside a "perceptual" facet, he also argues for the presence of both "subjective" and "behavioural" dimensions, the former relating to cognition and affect, and the latter to situational avoidance. Similarly, Cash (1994) has argued that attitudinal satisfaction is itself multifactorial, comprising two "largely independent" (Cash & Szymanski, 1995, p. 466) "evaluative" and "investment" dimensions. The former has been demonstrated through factor analysis (Cash, 1994) to comprise both cognitive appraisal and related affect, and is similar to Thompson's (1990) subjective dimension. However, Cash's investment factor has been shown to be broader than Thompson's behavioural equivalent as it incorporates the significance or meaning of appearance to the individual in addition to their

invested thought and behaviour. Muth and Cash (1997) argue that examination of each facet; evaluation, affect and investment is essential to an understanding of BD.

Theories of BD

Sociocultural theories have highlighted the role of family, peers and the media (Stice, 2002) in the development of BD. Much of the work has focused predominantly on female groups, within the field of eating disorders. Within this arena, work has explored the aetiological importance of societal pressures for thinness inherent in Western culture (e.g. Garner & Garfinkel, 1980). Stice argues that sociocultural pressures arising from a variety of sources may operate through a number of mechanisms including the modeling of dissatisfied behaviour by observable others, unfavourable social comparison and social reinforcement. The latter process involves the internalisation of values and attitudes presented as positive by others (Stice, 2002), potentially including the often unattainable ideals of body-shape promoted by the media. Although the notion of overvalued thinness with respect to societal female ideals is well established (e.g. Garner & Garfinkel, 1980), less is known about the corresponding pressures on men.

The different processes outlined by Stice (2002) by which sociocultural pressures may operate are difficult to separate because comparisons may be drawn by individuals between themselves and ideals internalised through social reinforcement, or indeed more directly between themselves and the external figures projected in the media (Grogan, 1999). That the process of

drawing such unfavourable comparisons should result in a negative self-image is reflected in Jourard and Secourd's (1955) conceptualisation of BD, whereby individuals' "body-cathexis" or rated satisfaction with the body was shown to be reliant upon the extent to which it both objectively conformed and was perceived to conform to shared normative ideals. The notion of comparison is also in keeping with self-discrepancy theory (Higgins, 1987). Perceived incongruence between one's "actual" self and the self one would ideally like to be (the "ideal self") was found to be significantly associated with BD in a non-clinical female sample (Strauman, Vookles, Berenstein, Chaiken, & Higgins, 1991). Self-discrepancy theory offers a developmental perspective to the understanding of BD. According to Strauman et al. (1991) the types of self-attribute considered important in adolescence are typically reliant on social comparison, rendering adolescents increasingly vulnerable to discrepancy and emotional distress. This is in keeping with a focus in the literature on maturation and puberty as possible factors in the development of BD (e.g. McCabe, Ricciardelli, & Finemore, 2002).

Sociocultural theories of BD focus largely on factors contributing to the development of disturbance, for example emphasising the role of the media in female groups. However, Cash (1994) proposes a cognitive behavioural framework for understanding both the aetiology and maintenance of such disturbance which is less tied to gender. Cash (1994, 2002) argues that individuals with strong investment in their appearance hold particular appearance-related schemas, which are activated by salient proximal events. Self-evaluation arising from such schema-activation results in the experience of negative thoughts and affect, which prompts individuals to implement

various cognitive and behavioural strategic responses. This cognitive behavioural model proposes that the more distal aetiology of body image dysfunction lies in the formation of maladaptive appearance-related schemas. This is not contrary to the alternative theories described; indeed, social reinforcement may serve to lay down or strengthen existing schemas. In view of this, the cognitive behavioural theory outlined by Cash (1994, 2002) provides a useful model for understanding the processes underlying BD which augments rather than replaces existing research findings.

BD in Men

The Nature and Extent of BD in Men

There is some evidence within the literature to suggest that males are generally more satisfied with their appearance than females. In a large scale US survey, Berscheid, Walster, and Bohrnstedt (1973) found that a greater percentage of women (23%) expressed some dissatisfaction with their overall appearance than did men (15%). However, the authors failed to indicate whether this difference was statistically significant. In addition, although this study employed a large sample (N = 2000) and participants were stratified according to national distributions with regard to age and gender, the generalisability of the findings may be limited; participants were readers of *Psychology Today* and may not have been representative of the general population. However, this apparent gender differential in BD has received support from further studies. In a sample of individuals aged between 10 and

79 years Pliner, Chaiken, and Flett (1990) found that females reported significantly poorer appearance-related self-esteem than did men. Moreover, the authors noted that this discrepancy persisted across the lifespan.

Despite the limitations of their survey research it is notable that Berscheid et al. (1973) cite weight satisfaction as an important contributor to overall evaluation, stating that: "those who are happy with their weight are also more satisfied with their bodies" (p. 121). Indeed, within the literature indices of satisfaction with weight and shape are often used synonymously to refer to "body" satisfaction (Cash & Szymanski, 1995). This is likely to have been influenced by the fact that much BD research has been conducted within the field of eating disorders. Indeed, the greater satisfaction men apparently feel for their bodies and in particular their weight has been cited as accounting for the gender differential seen in eating disorder diagnoses (e.g. Drewnowski & Yee, 1987). Giving a more specific focus to weight and shape whilst supporting the reputed BD gender differential, Fallon and Rozin (1985) found that while female students believed their current figure to be significantly larger than their ideal, there was no significant discrepancy between the male students' mean current and ideal ratings.

Whilst a number of studies have indicated an increased prevalence of BD in women, there remains some debate within the literature. For example, although Drewnowski and Yee (1987) found that female University students expressed a wish to lose weight significantly more often than male students (85% of females compared to 45% of males), a further 40% of men wished to gain weight. Thus, the proportion of men and women expressing some dissatisfaction with their body weight was comparable. This pattern of

findings has since been replicated in an UK sample of adolescent boys (Furnham & Calnan, 1998). In view of their findings, Drewnowski and Yee propose that the apparent correspondence of current and ideal body weight noted in Fallon and Rozin's (1985) male sample may have obscured the actual degree of BD experienced by the men.

In view of more recent conceptualisations of attitudinal body image as multidimensional (e.g. Cash, 1994; Muth & Cash, 1997), assessments based solely on the cognitive evaluation of body image cannot be considered comprehensive. Gender differences with regard to BD may vary according to the particular dimension assessed (Cash & Brown, 1989). With this in mind, conclusions drawn from studies examining only one facet of BD are likely to be limited. Studies assessing the multiple dimensions of body image have, however, produced conflicting results. Cash and Brown (1989) found that although female undergraduates were significantly more "appearance oriented" and showed significantly greater concern with weight than their male counterparts, there was no gender difference with regard to their appearance evaluations or overall satisfaction. In contrast, Muth and Cash (1997) have more recently found that in addition to showing stronger investment in their appearance and more frequently experiencing negative affect in relation to their appearance, female students made significantly more negative appearance self-evaluations than did their male counterparts.

The variation apparent within research findings may be influenced to some extent by the validity of assessment tools used. For example, although the measure employed by Cash and Brown (1989); the Multidimensional Body-Self Relations Questionnaire (MBSRQ), has been normed using both

male and female groups (Cash, Winstead, & Janda, 1985, 1986), its weight attitude scale refers most commonly to weight loss. Given that dissatisfied males are likely to be divided into those wishing to lose and those wishing to gain weight (Drewnowski & Yee, 1987), such unidirectional measures may be inappropriate as tools for the assessment of BD in males. This may have accounted for the significant gender differences noted with respect to weight concern within this study.

Although research findings are, therefore, constrained by limitations in the assessment tools used, they currently remain the only basis for examining BD in men. Notwithstanding these limitations, there is evidence to suggest that levels of dissatisfaction are increasing among men. In a follow-up to Berscheid et al.'s (1973) survey Cash et al. (1986) noted that the proportion of men reporting some dissatisfaction with their bodies (34%) was both greater than that found previously and more similar to the percentage of dissatisfied women (38%). In a more recent follow-up the proportion of those dissatisfied with their overall appearance had increased further to 43% and 56% of men and women, respectively (Garner, 1997). In line with these findings, Mishkind, Rodin, Silberstein, and Striegel-Moore (1986) reported that 95% of men within their sample expressed some dissatisfaction with their bodies, while Grogan (1999) noted that 72% of men surveyed claimed they would "feel better if they became more muscular" (p. 62).

To conclude, it remains unclear as to whether men are equally (e.g. Cash & Brown, 1989; Drewnowski & Yee, 1987) or less dissatisfied with their appearance (e.g. Berscheid et al., 1973; Cash et al., 1986; Muth & Cash, 1997) than women. Variation in the extent to which measures of BD are

weight-specific or more globally-oriented, in the particular cognitive-behavioural dimension of BD examined and in the appropriateness of assessment tools used may account for some of the inconsistency seen in findings. In addition, the rates of male BD reported have varied over time. However, the precise extent of the debated gender differential is arguably of less importance than the notion that those men who are dissatisfied may be subject to the various negative sequelae associated with BD including low self-esteem (Mishkind et al., 1986), muscle dysmorphia and eating disorders (Cohane & Pope, 2001). This has clear clinical significance, whether this group of men more closely approximates 34% (Cash et al., 1986) or 95% (Mishkind et al., 1986) of the general population.

The Ideal Male Body

Consideration of what constitutes an "ideal" male body is central to a discussion of male BD. In line with self-discrepancy theory (Higgins, 1987), the internalisation of shared societal ideals may underpin the development of "actual-ideal" discrepancies, engendering BD and emotional distress. Examination of changing trends in the male ideal over time may also contribute towards an understanding of why growing numbers of men are apparently becoming dissatisfied with their bodies.

The mesomorphic body type is commonly cited (e.g. Grogan, 1999; Mishkind et al., 1986) as the normative male ideal. Within this, Mishkind et al. propose that the majority prefer a "muscular mesomorphic" type. Indeed, Furnham and Calnan (1998) are unequivocal in their statement that "the male

ideal is a V-shaped figure" (p. 59), while Dibiase and Hjelle (1968) found that male undergraduates rated mesomorphic silhouettes as more active, energetic and dominant than either ecto- or endomorphic equivalents. Grogan (1999) explains the prevalence of this mesomorphic ideal in terms of its relation to "Western cultural notions of maleness as representing power, strength and aggression" (p. 58). Not only is the typical male ideal muscular, there is evidence to suggest that it is becoming more so. Male bodies, both as depicted in *Playgirl* magazine centrefolds (Leit, Pope, & Gray, 2001) and as children's action figure toys (Pope, Olivardia, Gruber, & Borowiecki, 1999) have become increasingly muscular over time, while Labre (2002) cites evidence to suggest that the range of fitness, health and appearance oriented publications directed toward the male audience has burgeoned. The argument that, for a large number of men, the real-ideal discrepancy is likely to be widening is in keeping with the increases in male BD noted within Western society, while the emphasis on muscularity explains why a substantial proportion of those men who are dissatisfied wish to gain weight.

Although there is general agreement regarding the most typical male ideal within modern Western society, it is unlikely that this ideal is endorsed by all groups of men. For example, in an analysis of personal advertisements drawing on the assumption that "[if a] body shape descriptor was mentioned, it was valued and important" (Epel, Spanakos, Kasl-Godley, & Brownell, 1996, p. 267) and thus reflective of ideals, Epel et al. found that African-American men described significantly higher body mass indices (BMI) than did Euro-American men. In addition, a high valuation on slimness, purported to be characteristic of gay male subculture (e.g. Williamson, 1999), has been

cited by Andersen (1999) as a risk factor for the increased rates of disordered eating noted in this group (e.g. Siever, 1994; Williamson & Hartley, 1998). Whilst an appreciation of the varying ideals proposed for different male groups may be valuable in contributing towards an understanding of the type and extent of BD within males, such ideals remain themselves only moderately understood and are deserving of further research attention.

To summarise, although there is general consensus that the most commonly endorsed male ideal is that of the V-shaped muscular mesomorph (e.g. Furnham & Calnan, 1998; Mishkind et al., 1986), evidence suggests that the most valued body type may vary between different groups. Sociocultural theory emphasising the internalisation of societal values in the development of BD would predict that those males endorsing such ideals most strongly will be at particular risk of BD and its related sequelae. A number of such vulnerable sub-groups have been documented within the literature. Examination of this research is helpful in the further elucidation of the pathways by which BD may develop and in the identification of its associated risk factors in men. Moreover, the increased prevalence of BD purported to exist within these groups has been linked to various clinical outcomes. Examination of this literature is critical in highlighting the clinical significance of BD for men.

Vulnerable Subgroups and Clinical Outcome

Gay men. Gay males have frequently been highlighted as a group at particular risk for BD and are arguably over-represented in male eating disordered populations. A number of studies have found homosexuality and bisexuality (e.g. Bramon-Bosch, Troop, & Treasure, 2000; Schneider & Agras, 1987), as well as an absence of sexual experience (e.g Herzog, Norman, Gordon, & Pepose, 1984) to be significantly more common among male than female bulimic and mixed-diagnosis groups of eating-disordered patients. However, sample sizes have typically been small, ranging from 15 to 30 males in those studies cited, and within the mixed-diagnosis samples comparisons have often not been diagnosis-specific. In their larger sample of 135 eating disordered male patients Carlat, Camargo, and Herzog (1997) found that while 42% of bulimic patients were either gay or bisexual, over half of their anorectic patients (58%) were asexual. It is possible that a gay orientation in males may be associated specifically with bulimia nervosa rather than with eating disorders per se. Although a minority of studies have found no association between homosexuality and either anorexia (e.g. Hall, Delahunt, & Ellis, 1985) or bulimia nervosa (e.g. Pope, Hudson, & Jonas, 1986) in men, these studies are again subject to a number of limitations. Hall et al.'s sample constituted only 9 patients and of Pope et al.'s 14 participants who were not reported as having a gay orientation, 1 failed to provide a sexual history while 2 were aged 16. As noted by Herzog, Bradburn, and Newman (1990), adolescent males may not have completed the process of establishing a sexual identity. Moreover, research within non-clinical samples

has replicated the association noted between eating disordered behaviour and homosexuality in men in the various clinical groups and has also enabled the further development of theoretical pathways by which this association may occur and in which BD has been implicated.

In their early survey Berscheid et al. (1973) noted that gay male respondents were significantly less likely to have a positive body image than their heterosexual counterparts. This finding has since been replicated in both US and UK samples. Mishkind et al. (1986) noted that American homosexual men recruited from gay student organisations reported greater dissatisfaction with their body build, waist, arms, biceps and stomach than a control sample of undergraduate males. In an UK sample of young adult males, Williamson and Hartley (1998) found that gay men both more often indicated preference for a slimmer body ideal than did their heterosexual counterparts and scored significantly higher on ratings of dissatisfaction with their own body parts. In addition, compared with control men, the gay men in each of these studies demonstrated significantly greater mean discrepancy between ratings of their actual and ideal self based on figure drawings. Not only were gay participants clearly more dissatisfied with their bodies, they were found in each study to score significantly more highly on measures of disordered eating with regard to both restrictive dieting and bulimic behaviours.

The increased value placed on thinness and greater rate of BD noted within gay male groups is in keeping with sociocultural and self-discrepancy theories. However, the pathway underlying the increased prevalence of BD within this group may be more complex. In their gay male group but not in

their heterosexual group, Williamson and Hartley (1998) noted an additional association between BD, eating disordered behaviour and overall self-esteem. Moreover, within the group of gay men, those who described themselves as generally satisfied with their sexual orientation reported significantly less BD than those whose sexuality was ego-dystonic. However, the number of participants in each of these groups was not clearly reported. In accordance with their findings, Williamson and Hartley (1998) propose a model whereby "internalised homonegativity" may impact detrimentally on self-esteem and interact with the images of the slender male ideal endorsed by the gay community to increase the vulnerability of homosexual men to BD and to the development of eating disorders. However, although Russell and Keel (2002) support Williamson and Hartley's findings in as much as gay participants scored significantly more highly than those in a heterosexual group on measures of both BD and eating disturbance, these differences remained when participants' degree of comfort with their sexual orientation was taken into account. Thus, Russell and Keel's findings suggest that factors relating to internalised homonegativity may be insufficient to explain the increased levels of BD noted within their homosexual group. This discrepancy may be partly accounted for by differences in the age of participants in the two studies; although age, entered as a covariate by Russell and Keel, did not account for the differences between gay and heterosexual groups in their study, the men within their gay group were older overall (M = 29.1 years) than those sampled by Williamson and Hartley (1998; M = 19.5 years). Indeed, Williamson and Hartley predict that the relationship between BD and global self-esteem would be less marked in

older gay men whose sexual identity may be more integrated overall. Nonetheless, this discrepancy in findings raises the possibility that alternative or additional factors may play some role in contributing towards the increased levels of BD evident in gay male groups.

"Sexual objectification" by male sexual partners has been highlighted (Siever, 1994) as a potentially common factor underlying the typically high rates of BD in both heterosexual female and gay male groups. In a multiple comparison study of gay male, lesbian and heterosexual male and female groups, Siever found lesbian women reported less dissatisfaction with their bodies as indexed by the BD subscale of the Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983) than those in the heterosexual group. This finding suggests that homosexuality, per se, is insufficient to account for the increased prevalence of BD generally seen in gay men. Replicating findings discussed previously, gay men in this study reported significantly higher rates of BD than heterosexual males on each of a variety of measures including ratings of satisfaction with body parts, current-ideal weight and shape discrepancy calculations and total scores on the Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987) and the BD subscale of the EDI. Interestingly, the degree to which gay men differed from heterosexual females on these measures varied according to the likely applicability of each measure to male groups. Siever notes that heterosexual women scored most highly on both the BSQ and EDI-BD subscale, each developed using exclusively female samples. In contrast, gay men showed the highest levels of BD with regard to the extent of their actual-ideal shape discrepancy and did not differ significantly from heterosexual females in

terms of their rated satisfaction with body parts; these methodologies being developed for use by both males and females.

Notwithstanding these limitations, Siever's (1994) sexual objectification hypothesis is given support by the finding that both gay males and heterosexual females rated their physical appearance as significantly more important to potential sexual partners than did lesbian women. In further support of the importance of this factor, Boroughs and Thompson (2002) have noted that figure drawings identified by gay men as representative of their partners' preferences were significantly thinner than those chosen by heterosexual males. Finally, similar findings have been noted for adolescent groups. In a survey of students aged 12 to 20 years French, Story, Remafedi, Resnick, and Blum (1996) found that while lesbian participants were significantly less likely to perceive themselves as overweight and significantly more often held a positive body image than heterosexual females, gay males reported a negative body image significantly more often than did those in the heterosexual group.

Given the purported over-valuation on thinness inherent in the gay male community, the focus within this research on BD regarding weight loss is reasonable. However, as discussed previously, dissatisfied males may often be more typically divided into those wishing to lose weight and those wishing to gain weight (e.g. Drewnowski & Yee, 1987; Furnham & Calnan, 1998). Men engaging in sports in which high or low weight is either emphasised or necessitated (e.g. bodybuilding, wrestling) have been highlighted as at risk of BD (e.g. Labre, 2002). Moreover, the type of sport in which men are engaged has, in turn, been linked to distinct clinical outcomes.

Athletic men. Athletes whose sport demands a low weight, such as running or wrestling, may be at increased risk of disordered eating (e.g. Braun, Sunday, Huang, & Halmi, 1999; Yates, Leehey, & Shisslak, 1983). However, the role of BD within this remains unclear. Boroughs and Thompson (2002), for example, found no difference in rated satisfaction with body parts between male runners and non-exercising controls. Equally, whilst investment in body image or "undue influence of body weight or shape on self-evaluation" (American Psychiatric Association [APA], 1994, p. 545) plays a central role in both anorexia and bulimia nervosa, BD may not be assumed on the basis of disordered eating per se. Thus, although Enns, Drewnowski, and Grinker (1987) found male wrestlers scored significantly higher than groups of skiers and swimmers on the Eating Attitudes Test (EAT; Garner & Garfinkel, 1979), the only items contributing to this difference related to past weight change and dieting behaviour. The authors note that these factors are possibly essential requirements of competitive wrestling and, in view of this, argue that the high scores observed in these participants do not necessarily reflect eating disorder psychopathology. However, Enns et al. note that a minority of wrestlers scoring above what has been considered a clinical cut-off for the EAT (Garner & Garfinkel, 1979; Garner & Garfinkel, 1980) also endorsed several items on the "drive for thinness" subscale. None of the skiers or swimmers scored within the clinical range. Whilst, in the absence of eating disorder psychopathology, sport-related weight reduction behaviours may not be presumed to reflect underlying BD, engagement in such sport and behaviours may be associated for some individuals, with BD. However, it is not possible to infer causality from these findings.

Males engaging in high-weight sports and bodybuilding in particular have been highlighted as vulnerable to increased BD (e.g. Mangweth et al., 2001) regarding both weight gain; i.e. increased muscularity, and an increased drive for thinness; i.e. loss of fat (e.g. Blouin & Goldfield, 1995). However, findings are not always consistent. Whilst bodybuilders in Blouin and Goldfield's study exhibited a greater degree of BD then either runners or martial artists, those recruited by Boroughs and Thompson (2002) were significantly more satisfied with regard to ratings of specific body parts than were either runners or non-exercising controls. The reason for this discrepancy remains unclear. Whilst it may be postulated that the increasing muscularity resulting from bodybuilding may bring some men closer to an ideal, thus increasing satisfaction, bodybuilders in Boroughs and Thompson's study did not differ significantly from either runners or controls in terms of their actual-ideal torso or overall body size discrepancies. However, some differences are notable. Whilst bodybuilders in Boroughs and Thompson's study were recruited from a University participant pool, those sampled by Blouin and Goldfield were recruited at fitness centres and included competitive body builders; they were therefore likely to have been more invested in their bodybuilding behaviour.

Certainly, a proportion of bodybuilders appear to be vulnerable to BD. In a sample of 108 bodybuilders, Pope, Katz, and Hudson (1993) noted that 2.8% reported a history of anorexia nervosa while 8.3% met the criteria proposed by the authors for "reverse anorexia", a disorder characterised by subjective perceptions of smallness or being underweight. Interestingly, 2 of the 9 men presenting with reverse anorexia were also among those reporting

a history of anorexia. In view of this, Pope et al. argue that bodybuilders may be at increased risk of body image disturbance in general, while this vulnerability may interact with more specific sociocultural factors to determine the subsequent manifestation of a particular clinical disorder. In addition, Pope et al. noted a significant association between the presence of reverse anorexia and steroid use, although findings among participants were mixed regarding which of these difficulties had predated the other. Pope et al. suggest two possible pathways to account for this; one in which BD associated with reverse anorexia may result in steroid use, and one in which reverse anorexia may develop following increased association with other more muscular steroid users. Clearly, it is not possible based on these findings to determine whether bodybuilding behaviour, and indeed steroid abuse, may predispose men towards BD or whether those men who are most dissatisfied engage in more extreme compensatory behaviours in response to their distress. However, given the range and severity of the side-effects associated with steroid use (see Labre, 2002 for a brief review) this is an area that clearly warrants further investigation.

Overweight and underweight men. Sociocultural and self-discrepancy theory predict that individuals will experience dissatisfaction with their appearance to the extent to which it differs from internalised ideals. Distortions of bodily perception may engender BD by increasing the gulf between such ideals and individuals' perceived body shape or weight. Alongside this, it is probable that BD will also be more prevalent among those whose actual appearance differs substantially from their accepted ideal. Accordingly, obesity has been highlighted by some authors as a risk factor

for eating disorders in males (e.g. Andersen, 2002), whilst adolescent boys with a higher BMI have been shown to report more dissatisfaction with muscle tone than their lighter peers (McCabe & Ricciardelli, 2001). However, in their review of the literature concerning eating disorders in boys Robb and Dadson (2002) note that research findings regarding whether overweight boys are indeed unhappier than their peers remain inconclusive. Cohane and Pope (2001) argue that weight dissatisfaction in boys may be masked by assessments utilising only a thinner-fatter dimension, which do not take into account boys' wishes to become more muscular. Thus, overweight boys who wish to replace fat with muscle mass may appear to be satisfied given that they do not wish to lose weight per se.

Various studies have indicated that the normative male ideal is that of the muscular mesomorph (Mishkind et al., 1986). Males who are underweight in reality may, therefore, be at increased risk of BD owing to an increased actual-ideal discrepancy and may be vulnerable to the development of clinical disorders. Indeed, Labre (2002) notes that males attempting to gain weight may be vulnerable to the development of binge eating disorder, while Blouin and Goldfield (1995) found that steroid abuse was significantly predicted by desire for bulk. Further research is required fully to elucidate the risks for BD and its sequelae within objectively over- and underweight males.

Body dysmorphic disorder. Much of the literature reviewed has considered BD in relation to body weight and shape specifically, as is evident in the focus on the eating disorders and reverse anorexia as potential sequelae. Indeed, as mentioned previously, weight and body dissatisfaction are commonly used interchangeably in the literature. However, that body

image refers more accurately to one's appearance as a whole suggests that non weight-related BD, although more sparsely researched, is also pertinent to this review.

The reverse anorexia described by Pope et al. (1993) has since been termed "muscle dysmorphia" (Pope, Gruber, Choi, Olivardia, & Phillips, 1997) and considered as a more specific form of body dysmorphic disorder (BDD). BDD, referring to a marked and distressing preoccupation with an imagined or exaggerated defect in some aspect of one's appearance (APA, 1994) is considered a "disturbance of body image" (Veale et al., 1996, p. 717) although the exact nature and relative role of perceptual and attitudinal dimensions within this disturbance remain unclear. Indeed, while participants with dysmorphia have shown greater self-ideal body image discrepancies than controls indicating greater levels of BD overall (Hardy, 1982), Phillips (2002) concludes that whether this dissatisfaction is underpinned by attitudinal dissatisfaction or by some perceptual abnormality is not known. Contrary to the more traditional notions of perceptual distortion typically associated with eating disorder research (e.g. Garner & Garfinkel, 1981), Veale et al. (1996) propose that patients with BDD may be more accurate than controls in appraisals of their appearance due to heightened selective attention.

Arguably, overall BD may act as an index of increased investment in appearance generally and highlight vulnerability to the development of BDD. The nature of risk factors for BDD, however, remains poorly understood (Phillips, 2002). Nonetheless, the significant impairment resulting from this disorder (APA, 1994) as well as its common association with depression,

social-phobia, obsessive compulsive disorder and high rate of suicidality (Phillips, 2002) highlight the importance of further research in this area. Measures of BD may be useful in identifying those at risk for BDD. Given that the dissatisfaction reported by patients with BDD is commonly associated with hair or with facial features (Phillips, 2002; Veale et al., 1996), many current measures of BD which emphasise dissatisfaction with weight and shape more specifically may be of limited use in this context. The argument that BDD may be equally prevalent, or with respect to muscle dysmorphia more common, in men (Phillips, 2002), further highlights the need for a measure of BD that specifically addresses issues of male concern.

Influences on Body Image in Men

Research examining specific subgroups of men who show elevated levels of BD is helpful in identifying potential risk factors for BD. Such risk factors range from issues relating to sexuality such as objectification, internalised homonegativity and its more general impact on self-esteem, to engagement in activities with high emphasis on particular body-ideals. Within overweight and underweight groups of men, actual body weight may also act as a risk factor to the degree to which it differs from an individual's internalised ideal. However, the extent to which such risk factors, identified within specific vulnerable groups, may apply to men across the population is not clear. A number of studies have examined the broader influence of sociocultural factors on male body image more generally.

That changing trends in the hegemonic (that is, most dominant) male ideal over time are reflected in the media has already been noted (e.g. Leit et al., 2001). Proponents of sociocultural (and self-discrepancy) theory, wherein BD may be engendered by self-comparison with either external figures in the media or an internal representation of these values, would also predict that the media may be responsible for causing such changes and for increasing the prevalence of BD in male groups. In an examination of the direct effects on men of exposure to media images of the hegemonic "hypermesomorphic" ideal, Leit, Gray, and Pope (2002) found that male undergraduate students exposed to such images within a controlled setting reported a significantly greater perceived current-ideal discrepancy on an index of muscularity than did a group of control men who had viewed only body-neutral material. However, Leit et al. failed to compare the body image ratings of their experimental and control groups prior to this exposure; thus, the reported findings may have reflected an existing difference between groups. Given the limited duration of exposure possible within an experimental setting, Leit et al. suggest that their findings may be an underestimate of an authentic media effect. However, Grogan (1999) proposes instead that the findings of such experimental research in which participants are "given something specific to observe (rather than choosing it themselves) ... and ... are (usually) asked to pay attention to details of the material they view" (p. 98) are essentially limited in their validity.

Grogan (1999) reports interview data indicating that whilst boys identified muscular role-models in the media and bodybuilding adults frequently made self-critical comparisons with the muscular ideals portrayed

on television and in magazines, the majority of adult men interviewed indicated that the impact of the media on their own body satisfaction was negligible. These findings may indicate that the muscular ideals portrayed within the media do not have an uniform effect. Alternatively, certain groups of men may be less willing to acknowledge the influence of such media.

Although Grogan (1999) suggests that media may be more important to younger males, findings within adolescent samples remain equivocal. Ricciardelli, McCabe, and Banfield (2000), for example, found that only 20% of boys interviewed perceived the media to have a negative effect on their body image, with 50% reporting no effect and indeed, 27.5% a positive effect. Moreover, in a large sample of adolescents McCabe et al. (2002) found that although, as would be predicted from prevailing norms, boys perceived significantly more media pressure than girls to increase their muscle tone, this was not significantly associated with overall body concern. Within a more detailed examination of media impact on middle school children Smolak, Levine, and Thompson (2001) found that while, for boys, awareness of sociocultural ideals was not related to reported satisfaction with weight and shape specifically, and correlated only marginally with an overall measure of BD, internalisation of societal values was significantly related to each of these. A further distinction was evident within the relationship between sociocultural influence and boys' body change behaviours. Whilst internalisation of societal values contributed significantly and exclusively to the use of muscle building techniques, only BMI was related significantly to behaviours aimed at weight loss. Thus, the internalisation of sociocultural ideals may impact differently on the use of various compensatory strategies

associated with BD. Given that items comprising the internalisation subscale within the male version of the Sociocultural Attitudes Towards Appearance Questionnaire (Heinberg, Thompson, & Stormer, 1995), developed by Smolak et al. (2001) for this study, emphasise the dominant muscular ideal it is perhaps not surprising that high scores on this measure were associated with strategies (and presumably desires) for weight (muscle) gain rather than loss. Further investigation is required to determine the extent to which these findings may apply to groups of adult men.

With respect to research regarding the impact of media on adult men, it is not possible to infer any causative effect for male groups overall within the association noted qualitatively by Grogan (1999) between media influence, BD and bodybuilding behaviour. Arguably, some third factor which predisposes an individual towards BD and to bodybuilding behaviour may also increase their consumption of related media. Whilst it is not possible to resolve such issues of causality here, what is evident from the varying degree to which media influence was considered important by different groups of men is the role of individual difference. A cognitive behavioural model such as that proposed by Cash (1994, 2002) wherein sociocultural factors acting, for example, as either distal events in schema development or proximal triggers to their activation, would be able to account for such individual variation.

Whilst research regarding sociocultural influence commonly emphasises the role of the media, peers and family members may also act as important sources of social information (e.g. Stice, 2002). Indeed, early experience with family and peers may be critical in the formation of

appearance-related schemas, while media consumption may then vary according to and interact with individuals' existing beliefs. An association between childhood teasing and BD in both adult men and women has been noted (Cash et al., 1986), while Berscheid et al. (1973) have indicated that this relationship may be stronger among males. The role of such social information from family and peers requires further investigation in male groups. Whilst a proportion of boys in Ricciardelli et al.'s (2000) adolescent sample experienced negative feedback from parents, siblings and friends regarding their body shape and size, being told for example by fathers (10%) or male friends (10%) that they were too thin or by brothers (12.5%), male friends (7.5%) and mothers (7.5%) that they were too fat, the authors fail to indicate whether this was significantly related to boys' ratings of body satisfaction. However, Ricciardelli et al. indicate that positive maternal feedback was related to increased satisfaction, while those boys receiving comments from their mothers (20%) regarding the need to eat less or lose weight were significantly more likely to engage in dieting behaviours. Similarly, paternal suggestions that boys exercise more, reported by 17.5%, were significantly related to engagement in exercise behaviours. Whilst parental feedback is clearly central to boys' subsequent behaviours, the role of BD in mediating this effect remains unclear based on these findings. Moreover, the longer-term impact of such feedback received during adolescence on adult BD and behaviour requires further clarification. Longitudinal prospective research would be invaluable in further elucidating the role of both peers and family in the development of BD in males.

Behavioural Responses to BD in Men

A cognitive behavioural model of BD (e.g. Cash, 1994, 2002) predicts that unfavourable cognitive self-evaluation will trigger negative affect and result in the use of compensatory or coping behaviours. This general framework for BD is in keeping with Veale et al.'s (1996) more specific cognitive behavioural model of BDD wherein checking, avoidant and compensatory behaviours such as camouflage are utilised in order to temporarily reduce or avoid emotional distress and also serve to maintain the disorder. Behaviours such as avoidance of social situations, highlighted by Veale et al. as significant to BDD, may be pertinent to the maintenance of BD in general. However, in keeping with the dominance of weight and shape within the body image literature as a whole, most research regarding behavioural responses to BD has focused on the means by which individuals attempt to alter their body weight and shape, most often by engaging in dietary behaviours and exercise.

Research findings have typically indicated that dissatisfied males within both adult (see Grogan, 1999 for a brief review) and adolescent (e.g. McCabe & Ricciardelli, 2001; Ricciardelli et al., 2000) groups are more likely to engage in exercise than dieting behaviours. Given the proportion of males typically wishing to gain weight or bulk, one might expect an increased use of bulk-enhancing exercise among male compared to female groups. However, boys within Ricciardelli et al.'s (2000) sample used exercise for purposes of decreasing as well as increasing their body size. Exercise may be the

strategy most frequently employed by male groups irrespective of the nature of their dissatisfaction.

However, choice of body-change behaviour may be influenced by more than gender. Ricciardelli et al. (2000), for example, noted that male peers and family members were perceived as influencing boys' exercise behaviours more strongly than were females, while with regard to dieting, mothers had the most impact. Accordingly, Ricciardelli et al. argue for an effect of gender-specific reinforcement whereby male and female role models differentially reinforce the behaviours typical of their own gender. The type of behaviour chosen by boys is therefore likely to depend, in part, on the make up of their more immediate social environment.

Further factors influencing individuals' engagement in various body change behaviours have been noted in the literature, indicating that the more typical use of exercise as a strategy may not be uniform across all male groups. McCabe and Ricciardelli (2001), for example, found that in addition to exercising, boys with a higher BMI were more likely than their lower BMI counterparts to diet for weight loss purposes. Further variation has been noted with respect to sexuality; adolescent gay males in French et al.'s (1996) sample were significantly more likely to engage in frequent dieting behaviour than bisexual respondents, while both gay and bisexual individuals reported significantly greater laxative use than those in the heterosexual group. Whilst increased use of weight loss strategies such as dieting and laxative abuse by gay participants may be accounted for in part by the heightened value of thinness noted within gay male groups (e.g. Williamson & Hartley, 1998), further research is required to examine the normative ideals

held within bisexual groups. Moreover, the relationship between sexuality and choice of body change behaviour may be mediated by more than a culturally-endorsed desire for thinness. Whilst the engagement in dieting behaviours and laxative abuse reported by gay adolescents in French et al.'s sample may have been associated with a desire for weight loss, those interviewed by Ricciardelli et al. (2000) who wished to lose weight were still more likely to engage in exercise behaviours. A desire for thinness per se may therefore be insufficient to establish dieting behaviours. Unfortunately, French et al. do not provide any information relating to their participants' use of exercise for weight or shape control. French et al.'s (1996) findings are supported to some extent by Boroughs and Thompson (2002) who reported a marginally significant effect of sexuality in their adult sample; gay males engaging more frequently in dieting behaviours than those in the heterosexual group. Given that males may most typically choose exercise strategies when attempting to either gain or lose weight (Ricciardelli et al., 2000), an association between gay orientation and dieting behaviour may reflect more than a more frequent desire for weight loss in this group. Rather, an individual's engagement in specific compensatory behaviours may be influenced by wider factors such as the internalised homonegativity proposed by Williamson and Hartley (1998).

Adding further complexity to any simple eating versus exercise gender divide, McCabe et al. (2002) found that adolescent males were significantly more likely than females to use eating strategies to increase weight. Modification of eating behaviour in response to BD most typically refers to dieting for purposes of weight loss. Traditional measures of eating behaviour

as an index of BD may therefore fail to capture those behaviours that are relevant to men. Indeed, any measure of behaviour associated with BD, whose dimensions are restricted to eating and exercise strategies, is likely to be limited. In addition to diet and exercise behaviours, dissatisfied males may engage in dangerous practices such as steroid abuse, use of dietary supplements or other substances such as human growth hormone (Labre, 2002). Furthermore, Grogan (1999) notes that the use of cosmetic surgery is becoming increasingly common among men.

Given the clear implications for health of body-change behaviours such as dieting and exercise it is perhaps not surprising that these have received much of the research attention. Equally, the association within the literature between BD and eating disorder psychopathology has likely influenced this focus. However, given that BD most accurately refers to dissatisfaction with all aspects of appearance, behaviours not directly related to the modification of weight and shape are pertinent to this review.

Responses to BD such as avoidance or checking behaviours which are not aimed at changing one's appearance may still prove detrimental to mental health in perpetuating BD and maintaining distress. Certainly, checking and avoidance behaviours are highlighted as factors contributing to the maintenance of BDD (Veale et al., 1996) whilst body checking behaviours have also been implicated in the continuation of body size preoccupation in anorexia nervosa (Fairburn, Shafran, & Cooper, 1998). However, the role of these behaviours in more general or non-clinical BD in men remains unclear, partly because measures designed for their assessment such as the Body Image Avoidance Questionnaire (Rosen, Srebnik, Saltzberg, & Wendt, 1991)

and the Body Checking Questionnaire (Reas, Whisenhunt, Netemeyer, & Williamson, 2002) have often been developed and validated using exclusively female samples. In their interview study McCabe and Ricciardelli (2001) report that a small number of boys described behaviours such as wearing certain clothes to disguise their bodies or to make themselves look bigger. That boys in this study were able to volunteer this information highlights the value of an exploratory interview format in the absence of appropriate standardised assessment tools. A similarly open-ended interview study with adult male participants would be helpful in exploring the issues relating to behavioural outcome of BD for men.

Summary

The concept of body image has attracted research interest from a variety of traditions and perspectives over time. However, until recently research has commonly considered BD alongside eating disorder psychopathology and has relied upon predominantly or exclusively female samples. Accordingly, growing interest in the phenomenon of male BD has been constrained by the failure of existing tools comprehensively to assess the construct in men. Measures have been limited with respect to their lack of validation in male samples, their emphasis on weight or weight loss specifically, or their failure to address each dimension of the multidimensional body image construct. Arguably, the development of an appropriate tool for the assessment of BD in men is necessarily the first step in furthering an understanding of the phenomenon. A number of areas for further research

have been highlighted throughout this review. A valid assessment tool would enable further investigation into each of these.

Firstly, an appropriate assessment tool is necessary in order to establish accurate estimates of the prevalence of male BD. In keeping with a cognitive behavioural model of BD (e.g. Cash, 1994, 2002) insight into each of the triggers, experience and behavioural outcome of dissatisfaction is critical to an understanding of BD.

Research into possible triggers to or influences on BD in men has commonly focused on sociocultural factors with particular emphasis on the media. Understanding of these and other, for example, peer-related influences remains incomplete for adult men. As such, these areas warrant further investigation. Sociocultural theory emphasises the process of unfavourable self-comparison with hegemonic ideals in engendering distress. Whilst a muscular mesomorphic body type is typically cited as the normative male ideal (e.g. Grogan, 1999; Mishkind et al., 1986), the extent to which this ideal is endorsed by men may vary across different groups with respect to both ethnicity and sexuality. Given that aspiration towards such ideals has a potential aetiological role in the development of BD, the nature of ideals held by various minority groups and the way in which these may interact with additional factors in triggering BD requires exploration.

Certainly, that risk for BD among men does not appear to be uniform suggests that an aetiological pathway involving more than sociocultural factors is likely. Research examining those subgroups of men who appear to be particularly vulnerable to BD, including gay men and bodybuilding athletes, has begun both to identify potential risk factors for BD and to

highlight its various sequelae. Whilst research examining male behavioural responses to BD is limited, the clinical significance of certain associated outcomes which include eating disorders, muscle dysmorphia and steroid abuse is clear. As such, it is unacceptable that findings remain limited by the quality of the assessment tools used. Valid assessment is an essential prerequisite to the further exploration of the causative pathways by which such sequelae may develop. An understanding of such pathways may enable the development and evaluation of programmes for prevention and intervention that are tailored to the specific needs of men.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Andersen, A. E. (1999). Eating disorders in gay males. *Psychiatric Annals, 29(4),* 206-212.

Andersen A. E. (2002). Eating disorders in males. In C. G. Fairburn & K. D. Brownell (Eds.), *Eating disorders and obesity: A comprehensive handbook* (2nd ed., pp. 188-191). NY/ London, UK: The Guilford Press.

Berscheid, E., Walster, E., & Bohrnstedt, G. (1973). The happy American body: A survey report. *Psychology Today, 7,* 119-131.

Blouin, A. G., & Goldfield, G. S. (1995). Body image and steroid use in male bodybuilders. *International Journal of Eating Disorders, 18,* 159-165.

Boroughs, M., & Thompson, J. K. (2002). Exercise status and sexual orientation as moderators of body image disturbance and eating disorders in males. *International Journal of eating Disorders, 31,* 307-311.

Bramon-Bosch, E., Troop, N. A., & Treasure, J. L. (2000). Eating disorders in males: a comparison with female patients. *European Eating Disorders Review, 8,* 321-328.

Braun, D. L., Sunday, S. R., Huang, A., & Halmi, K. A. (1999). More males seek treatment for eating disorders. *International Journal of eating Disorders, 25,* 415-424.

Carlat, D. J., Camargo, C. A., & Herzog, D. B. (1997). Eating disorders in

males: A report on 135 patients. *American Journal of Psychiatry, 154(8),* 1127-1132.

Cash, T. F. (1994). Body-image attitudes: Evaluation, investment, and affect. *Perceptual and Motor Skills, 78,* 1168-1170.

Cash, T. F. (2002). The Situational Inventory of Body-image Dysphoria: Psychometric evidence and development of a short form. *International Journal of Eating Disorders, 32,* 362-266.

Cash, T. F. (2004). Body image: Past, present and future. *Body Image, 1,* 1-5.

Cash, T. F., & Brown, T. A. (1989). Gender and body images: Stereotypes and realities. *Sex Roles, 21(5/6),* 361-373.

Cash, T. F., & Szymanski, M. L. (1995). The development and validation of the Body-Image Ideals Questionnaire. *Journal of Personality Assessment, 64(3),* 466-477.

Cash, T. F., Winstead, B. A., & Janda, L. A. (1985). Your body, yourself: A reader survey. *Psychology Today, 19(7),* 22-26.

Cash, T. F., Winstead, B. A., & Janda, L. H. (1986). Body image survey report: The great American shape-up. *Psychology Today, 20(4),* 30-37.

Cohane, G. H., & Pope, H. G., Jr., (2001). Body image in boys: A review of the literature. *International Journal of Eating Disorders, 29,* 373-379.

Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairburn, C. G. (1987). The development and validation of the Body Shape Questionnaire. *International Journal of Eating Disorders, 6(4),* 485-494.

Dibiase, W. J., & Hjelle, L. A. (1968). Body-image stereotypes and body-type

preferences among male college students. *Perceptual and Motor Skills, 27,* 1143-1146.

Drewnowski, A., & Yee, D. K. (1987). Men and body image: Are males satisfied with their body weight? *Psychosomatic Medicine, 49,* 626-634.

Enns, M. P., Drewnowski, A., & Grinker, J. A. (1987). Body composition, body size estimation, and attitudes towards eating in male college athletes. *Psychosomatic Medicine, 49(1),* 56-64.

Epel, E. S., Spanakos, A., Kasl-Godley, J., & Brownell, K. D. (1996). Body shape ideals across gender, sexual orientation, socio-economic status, race, and age in personal advertisements. *International Journal of Eating Disorders, 19(3),* 265-273.

Fairburn, C. G., Shafran, R., & Cooper Z. (1998). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and therapy, 37,* 1-13.

Fallon, A. E., & Rozin, P. (1985). Sex differences in perceptions of desirable body shape. *Journal of Abnormal Psychology, 94(1),* 102-105.

Fisher, S. (1990). The evolution of psychological concepts about the body. In T. F. Cash & T. Pruzinsky (Eds.), *Body images: Development, deviance and change* (pp. 3-20). NY: Guilford Press.

Fisher, S., & Cleveland, S. E. (1958). *Body image and personality.* NY: D.Van Nostrand Company, Inc.

French, S. A., Story, M., Remafedi, G., Resnick, M. D., & Blum, R. W. (1996).

Sexual orientation and prevalence of body dissatisfaction and eating disordered behaviours: A population-based study of adolescents. *International Journal of Eating Disorders, 19(2),* 119-126.

Furnham, A., & Calnan, A. (1998). Eating disturbance, self-esteem, reasons for exercising and body weight dissatisfaction in adolescent males. *European Eating Disorders Review, 6,* 58-72.

Garner, D. M. (1997). *The 1997 body image survey results.* Retrieved January 10, 2003, from http://www.psychologytoday.com/htdocs/prod/ptoarticle/pto-19970201-000023.asp

Garner, D. M., & Garfinkel, P. E. (1979). The eating attitudes test: an index of the symptoms of anorexia nervosa. *Psychological Medicine, 9,* 273-279.

Garner, D. M., & Garfinkel, P. E. (1980). Socio-cultural factors in the development of anorexia nervosa. *Psychological Medicine, 10,* 647-656.

Garner, D. M., & Garfinkel, P. E. (1981). Body image in anorexia nervosa: Measurement, theory and clinical implications. *International Journal of Psychiatry in Medicine, 11(3),* 263-284.

Garner, D. M., Olmsted, M. P., & Polivy, J. (1983). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of eating Disorders, 2,* 15-34.

Grogan, S. (1999). *Body image: Understanding body dissatisfaction in men, women and children.* NY: Routledge.

Hall, A., Delahunt, J. W., & Ellis, P. M. (1985). Anorexia nervosa in the male: clinical features and follow-up of nine patients. *Journal of Psychiatric Research, 19(2/3),* 315-321.

Hardy, G. E. (1982). Body image disturbance in dysmorphophobia. *British Journal of Psychiatry, 141,* 181-185.

Head, H. (1926). *Aphasia and kindred disorders of speech.* London, UK: Cambridge University Press.

Heinberg, L., Thompson, J. K., & Stormer, S. (1995). Development and validation of the Sociocultural Attitudes Towards Appearance Questionnaire. *International Journal of Eating Disorders, 17,* 81-89.

Herzog, D. B., Bradburn, I. S., & Newman, K. (1990). Sexuality in males with eating disorders. In A. E. Andersen, (Ed.), *Males with eating disorders* (pp. 40-53). PA: Brunner/Mazel Inc.

Herzog, D. B., Norman, D. K., Gordon, C., & Pepose, M. (1984). Sexual conflict and eating disorders in 27 males. *American Journal of Psychiatry, 141(8),* 989-990.

Higgins, E. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological review, 94,* 319-340.

Jourard, S. M., & Secourd, P. F. (1955). Body-cathexis and the ideal female figure. *Journal of Abnormal and Social Psychology, 50,* 243-246.

Labre, M. P. (2002). Adolescent boys and the muscular male body ideal. *Journal of Adolescent Health, 30,* 233-242.

Leit, R. A., Gray, J. J., & Pope, H. G., Jr. (2002). The media's representation of the ideal male body: A cause for muscle dysmorphia? *International Journal of Eating Disorders, 31,* 334-338.

Leit, R. A., Pope, H. G., Jr., & Gray, J. J. (2001). Cultural expectations of muscularity in men: The evolution of Playgirl centrefolds. *International Journal of Eating Disorders, 29,* 90-93.

McCabe, M. P., & Ricciardelli, L. A. (2001). Body image and body change techniques among young adolescent boys. *European Eating Disorders review, 9,* 335-347.

McCabe, M. P., Ricciardelli, L. A., & Finemore, J. (2002). The role of puberty, media and popularity with peers on strategies to increase weight, decrease weight and increase muscle tone among adolescent boys and girls. *Journal of Psychosomatic Research, 52,* 145-153.

Mangweth, B., Pope, H. G., Jr., Kemmler, G., Ebenbichler, C., Hausmann, A., de Col C., et al. (2001). Body image and psychopathology in male bodybuilders. *Psychotherapy and Psychosomatics, 70(1),* 38-43.

Mishkind, M. E., Rodin, J., Silberstein, L. R., & Striegel-Moore, R. H. (1986). The embodiment of masculinity. *American Behavioral Scientist, 29(5),* 545-562.

Muth, J. L., & Cash, T. F. (1997). Body-image attitudes: What difference does gender make? *Journal of Applied Social Psychology, 27(16),* 1438-1452.

Phillips, K. A. (2002). Body image and body dysmorphic disorder. In C. G. Fairburn, & K. D. Brownell (Eds.), Eating disorders and obesity: A comprehensive handbook (2nd ed., pp. 113-117). NY/London, UK: The Guilford Press.

Pliner, P., Chaiken, S., & Flett, G. L. (1990). Gender differences in concern

with body weight and physical appearance over the life span. *Personality and Social Psychology Bulletin, 16(2),* 263-273.

Pope, H. G., Jr., Gruber, A. J., Choi, P., Olivardia, R., & Phillips, K. A. (1997). Muscle dysmorphia – an underrecognised form of body dysmorphic disorder. *Psychosomatics, 38(6),* 548-557.

Pope, H. G., Jr., Hudson, J. I., & Jonas, J. M. (1986). Bulimia in men: A series of fifteen cases. *The Journal of Nervous and Mental Disease, 174(2),* 117-119.

Pope, H. G., Jr., Katz, D. L., & Hudson, J. I. (1993). Anorexia nervosa and "reverse anorexia" among 108 male bodybuilders. *Comprehensive Psychiatry, 34(6),* 406-409.

Pope, H. G., Jr., Olivardia, R., Gruber, A., & Borowiecki, J. (1999). Evolving ideals of male body image as seen through action toys. *International Journal of Eating Disorders, 26,* 65-72.

Reas, D. L., Whisenhunt, B. L., Netemeyer, R., & Williamson, D. A. (2002). Development of the Body Checking Questionnaire: A self-report measure of body checking behaviours. *International Journal of Eating Disorders, 31,* 324-333.

Ricciardelli, L. A., McCabe, M. P., & Banfield, S. (2000). Body image and body change methods in adolescent boys: Role of parents, friends, and the media. *Journal of Psychosomatic Research, 49,* 189-197.

Robb, A. S., & Dadson, M. J. (2002). Eating disorders in males. *Child and Adolescent Clinics of North America, 11(2),* 399-418.

Rosen, J. C., Srebnik, D., Saltzberg, E., & Wendt, S. (1991). Development of

a body image avoidance questionnaire. *Psychological Assessment, 3,* 32-37.

Russell, C. J., & Keel, P. K. (2002). Homosexuality as a specific risk factor for eating disorders in men. *International Journal of Eating Disorders, 31,* 300-306.

Schilder, P. (1950). *The image and appearance of the human body: Studies in the constructive energies of the psyche.* NY: International Universities Press, Inc.

Schneider, J. A., & Agras, W. S. (1987). Bulimia in males: A matched comparison with females. *International Journal of Eating Disorders, 6(2),* 235-242.

Shontz, F. C. (1974). Body image and its disorders. *International Journal of Psychiatry in Medicine, 5,* 461-472.

Siever, M. D. (1994). Sexual orientation and gender as factors in socioculturally acquired vulnerability to body dissatisfaction and eating disorders. *Journal of Consulting and Clinical Psychology, 62(2),* 252-260.

Skrzypek, S., Wehmeier, P. M., & Remschmidt, H. (2001). Body image assessment using body size estimation in recent studies on anorexia nervosa. A brief review. *European Child and Adolescent Psychiatry, 10,* 215-221.

Slade, P. D. (1994). What is body image? *Behaviour Research and Therapy, 32(5),* 497-502.

Smolak, L., Levine, M. P., & Thompson, J. K. (2001). The use of the

Sociocultural Attitudes Towards Appearance Questionnaire with middle school boys and girls. *International Journal of Eating Disorders, 29,* 216-223.

Stice, E. (2002). Sociocultural influences on body image and eating disturbance. In C. G. Fairburn & K. D. Brownell (Eds.), *Eating disorders and obesity: A comprehensive handbook* (2nd ed., pp. 103-107). NY/ London, UK: The Guilford Press.

Strauman, T. J., Vookles, J., Berenstein, V., Chaiken, S., & Higgins, E. T. (1991). Self-discrepancies and vulnerability to body dissatisfaction and disordered eating. *Journal of Personality and Social Psychology, 61(6),* 946-956.

Thompson, J. K. (1990). *Body image disturbance: Assessment and treatment.* NY: Pergamon Press, Inc.

Veale, D., Gournay, K., Dryden, W., Boocock, A., Shah, F., Willson, R., et al. (1996). Body dysmorphic disorder: A cognitive behavioural model and pilot randomised control trial. *Behaviour Research and Therapy, 34(9),* 717-729.

Williamson, I. (1999). Why are gay men a high risk group for eating disturbance? *European Eating Disorders Review, 7,* 1-4.

Williamson, I., & Hartley, P. (1998). British research into the increased vulnerability of young gay men to eating disturbance and body dissatisfaction. *European Eating Disorders Review, 6,* 160-170.

Yates, A., Leehey, K., & Shisslak, C. M. (1983). Running - an analogue of anorexia? *New England Journal of Medicine, 308,* 251-255.

Running head: EXPERIENCE OF BODY DISSATISFACTION IN MEN

The Experience of Body Dissatisfaction in Men: An Exploratory Study

Gillian Adams*

School of Psychology, University of Southampton

* Address for Correspondence: School of Psychology, Doctoral Programme in Clinical Psychology, University of Southampton, Highfield, Southampton, SO17 1BJ, United Kingdom.

Tel.: +44(0)23 80595321; fax: +44 (0)23 8059 2588.

Email: gca201@soton.ac.uk

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Abstract

Evidence suggests that the prevalence of body dissatisfaction (BD) is increasing amongst men. However, existing tools for the assessment of BD are limited in their applicability to male groups. This study aimed to explore the phenomenon of BD in men, in order to elucidate its experiential components, and act as the first phase in development of a new assessment tool. Semi-structured interviews were conducted with 14 men. Qualitative analysis yielded 15 themes across 4 domains (societal, interpersonal, intrapersonal, and social presentation). Whilst participants exhibited a range of appearance concerns, there was commonality in the processes by which these were experienced and managed. These generic issues are the focus of the themes, and could be usefully incorporated into a new assessment tool. Findings are considered in relation to existing (cognitive behavioural, self-discrepancy, and sociocultural) theories, and possible implications for practice are discussed.

Keywords: Body dissatisfaction; Men; Qualitative analysis; Assessment

Introduction

Recent evidence suggests that the prevalence of body dissatisfaction (BD) amongst men may be on the increase (e.g. Garner, 1997). Although the phenomenon of BD has often been examined in female samples, there is evidence to indicate that male BD may differ qualitatively to that experienced by females. For example, with regard to weight concern specifically, whilst women commonly want to lose weight, men are more typically divided into those wishing to lose weight, and those wishing to gain weight (e.g. Drewnowski & Yee, 1987; Furnham & Calnan, 1998). Given that many measures of BD have been validated using female samples, it cannot be assumed that existing theory and findings will apply automatically to male groups. However, in view of the association of BD, in men, with a range of negative sequelae including low self-esteem (e.g. Mishkind, Rodin, Silberstein, & Striegel-Moore, 1986), muscle dysmorphia, (Cohane & Pope, 2001), and steroid abuse (e.g. Labre, 2002), its accurate assessment is critical. However, despite the many measures designed for the assessment of BD, the applicability of such measures to male groups remains limited in a number of respects.

Existing Tools for the Measurement of BD

Research into BD has typically distinguished between perceptual distortion and attitudinal dissatisfaction (Cash and Deagle, 1997; Skrzypek, Wehmeier, & Remschmidt, 2001). Accordingly, a range of tools has been

developed for the assessment of BD within each of these modalities. The present discussion will focus on those measures assessing the attitudinal component of BD, for the following reasons. Firstly, the extent to which measures of perceptual distortion actually index a construct that is separate to the attitudinal dimension is questionable. In their review of recent research on body image assessment, Skrzypek et al. (2001) concluded that perceptual estimates are related to attitude. Moreover, measures of perceptual distortion typically index estimations of body size (Cash & Deagle, 1997). Whilst this focus is pertinent to individuals with eating disorders, where disturbance in, and dissatisfaction with, body shape and weight play a central role (Shafran & Fairburn, 2002), it may be of less relevance to individuals experiencing dissatisfaction with other aspects of appearance. For example, Carr, Harris, and James (2000) note that dissatisfaction with a range of features, including skin blemishes or ageing, may cause significant distress.

While assessment tools can be categorised as measuring perceptual or attitudinal BD, further variation exists within the attitudinal domain. For example, appearance evaluation has been indexed via both questionnaire-based ratings of satisfaction with body parts (e.g. Berscheid, Walster, & Bohrnstedt, 1973; Franzoi & Shields, 1984; Secord & Jourard, 1953) and the degree of discrepancy between figure drawings identified by participants as corresponding to their "ideal" and "actual" selves (e.g. Fallon & Rozin, 1985). These types of measure are each subject to a number of limitations.

With regard to figure-based assessments, Cohane and Pope (2001) note a common failure to distinguish between increased size that is due to muscle and that which is due to fat; this may undermine the applicability of

such measures to male groups. Pope et al.'s (2000) computerised Somatomorphic Matrix, and the Bodybuilder Image Grid (Hildebrandt, Langenbucher, & Schlundt, 2004) are exceptions to this, allowing men to select figures on dimensions of both fatness and muscularity. However, while these are more appropriate as measures of male size satisfaction, they assess only one aspect of appearance. Moreover, given the typical male divide between those wishing to lose and those wishing to gain weight, group averages of figure-based discrepancies may be misleading (e.g. Drewnowski & Yee, 1987).

Questionnaire measures of satisfaction are similarly limited. A number of scales, such as the BD subscale of the Eating Disorders Inventory (EDI; Garner, Olmsted, & Polivy, 1983) have been devised in the context of eating disorder research, and are thus concerned specifically with desire for weight loss. Such unidirectional measures are limited by their failure to address male desires for increased muscularity, and attempts to remedy this bias have also often been unsatisfactory. For example, although some researchers have tailored existing measures such as the EDI to men, by adding male-relevant items (e.g. biceps and shoulders; Furnham & Calnan, 1998), or creating a "drive for bulk" subscale (Blouin & Goldfield, 1995), these modifications have not been standardised, nor their psychometric properties established. In contrast, Edwards and Launder (2000) developed the Swansea Muscularity Attitudes Questionnaire; a questionnaire specifically designed to address male concerns regarding muscularity. However, this measure fails to allow for desired weight loss and is therefore equally limited. Measures assessing weight concern, in relation to either weight loss or gain,

are also limited by their failure to address dissatisfaction with aspects of appearance that are not related to weight and shape.

The Body-Image Ideals Questionnaire (BIQ; Cash & Szymanski, 1995) includes a range of physical attributes, and assesses the degree to which respondents believe these are discrepant from personal ideals, as well as the importance to participants of this discrepancy. The expanded version (Szymanski & Cash, 1995) also includes the extent to which participants believe their attributes are discrepant from ideals held by others. However, whilst this measure represents an improvement on the figure-based discrepancy ratings previously described, it was only validated on a female population. Current conceptualisations view attitudinal BD as multidimensional (Cash & Deagle, 1997), comprising not only cognitive but also affective and behavioural elements. Therefore even questionnaire measures of satisfaction that do focus on wider aspects of appearance, and have included males in their development (e.g. Secord & Jourard, 1953), remain limited in assessing only one aspect of this construct.

In line with conceptualisations of attitudinal body image as a multidimensional construct, a further range of tools has been developed to assess each of its factors. For example, the behavioural dimension of BD has been addressed by means of the Body Image Avoidance Questionnaire (BIAQ; Rosen, Srebnik, Saltzberg, & Wendt, 1991) and Body Checking Questionnaire (BCQ; Reas, Whisenhunt, Netemeyer, & Williamson, 2002), while Cash (1994) developed the Situational Inventory of Body Image Dysphoria (SIBID) as an index of affect associated with BD. In addition to the cognitive-evaluative measures of satisfaction described previously, the

cognitive dimension of BD has been further tapped by the Beliefs about Appearance Scale (BAAS; Spangler & Stice, 2001), and appearance investment by the Appearance Schemas Inventory (ASI; Cash & Labarge, 1996). In addition to addressing only one dimension of the BD construct, however, each of these measures is limited in its applicability to male groups, in one or more respects.

The BIAQ was developed based upon the weight and shape concerns of female participants, while the item development process for both the BCQ and BAAS was informed by concerns specific to individuals with eating disorders. With regard to both the SIBID and ASI, the authors are, in each case, unclear regarding the process of item generation, stating only that the items were "derived from rational, empirical, and clinical sources" (Cash, 1994, p. 133), and "based on key themes in the body-image literature" (Cash & Labarge, 1996, p. 39), respectively. In their revision of the ASI, Cash, Melnyk, and Hrabosky (2004) again provide little detail; although the content and face validity of new items informed their development, the authors do not specify how this was conducted, or by whom. As Carr (2002) notes, it is possible that the content validity of such measures may be limited by the item generation process. Certainly, given that much of the BD literature has developed alongside female-dominated eating disorder research, the appropriateness of scales based upon this literature for male groups is questionable.

In recognition of the multidimensional nature of BD, and the failure of many measures to capture more than one aspect of the construct, Thompson (1990, 2004) recommends the use of multiple measures in assessing BD.

However, there are practical and ethical limitations to the administration of lengthy batteries, in both clinical and research settings, which highlight the need for a single, comprehensive measure. A number of measures have been devised with this in mind but are, also, limited with regard to their use with male respondents. While the Multidimensional Body-Self Relations Questionnaire (MBSRQ; Cash, 2000) is a broad measure assessing affect, cognition and behaviour across three dimensions; appearance, fitness, and health/ illness, it refers primarily to desired weight loss, having an overweight, but not underweight, preoccupation subscale. In addition, while the scale was standardised using a national survey sample (Cash, Winstead, & Janda, 1985, 1986), the authors fail to specify how items were derived. Furthermore, although Hildebrant et al.'s (2004) Muscle Dysmorphic Disorder Inventory takes account of cognitive, behavioural, and affective dimensions, it remains limited in its applicability to BD in general, having been devised with the diagnostic criteria of muscle dysmorphia in mind.

Other comprehensive measures include the Derriford Appearance Scale (DAS; Carr et al., 2000) and Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987). Although these two measures each effectively samples a range of BD dimensions, neither is appropriate as a comprehensive tool for non-clinical male groups, the former being developed using a clinical sample of plastic surgery patients, and the latter a sample of females. However, these scales deserve mention, in light of their particular strengths. Item content, for both the DAS and BSQ was derived directly from patient, or participant experience, illustrating a helpful model of instrument design.

This brief review has highlighted the need for a comprehensive measure of BD for use in male groups. Existing measures are commonly limited by their failure to incorporate either all aspects of appearance that are relevant to men, or all aspects of the BD construct. In addition, standardisation samples have often been exclusively female. In keeping with conceptualisations of BD as multidimensional, explication of each of the cognitive, behavioural, and affective elements of BD is essential to an understanding of the phenomenon in men. However, given its reliance upon existing tools, the current literature can neither be considered reliable in its representation of male experience, nor appropriate as a basis for developing a new measure. Given that little is known about the phenomenological experience of BD for men, exploration of this would be a valuable addition to the literature; elucidating the cognitive, affective, and behavioural components of male concerns. Furthermore, in line with the approach used by Cooper et al. (1987), such exploration would form the first phase in the development of a valid and appropriate assessment tool.

Research Aims

In light of the above review, the aim of this study was to explore the phenomenon of BD in men, through the use of semi-structured interviews. It was the intention of the research to develop understanding of the unique aspects of male experience, while at the same time taking some account of existing theory in the consideration of these data.

Methodological, Personal, and Theoretical Perspective

This study proposed to explore the phenomenon of BD in men using semi-structured interview data. Smith (1995) argues for a natural fit between semi-structured interview data and qualitative inquiry, while Patton (2002) states that qualitative methods are particularly appropriate for investigating phenomena for which there are no existing, appropriate assessment tools.

Within the qualitative tradition there is a range of theoretical perspectives available to researchers. The current study aimed, specifically, to explore the phenomenon of BD in men. Interpretative Phenomenological Analysis (IPA; e.g. Smith, 1995, 1996) was considered appropriate to this, given its concern with individual experience, and concurrent recognition that understanding of such experience is necessarily achieved through a process of interpretation (e.g. Smith & Osborn, 2003). Thus, although IPA is primarily inductive, the analyst may also draw on theory, and findings are considered in relation to the existing research (Smith, 2004). Further detail, regarding the epistemology of IPA, is given in Appendix B.

The researcher was a 26 year old white British female, in training as a Clinical Psychologist. In keeping with IPA, the researcher adopted a critical realist position (Larkin, 2003) with regard to the status of interview data, and acknowledged a broad affiliation with cognitive-behavioural principles, anticipating that these would play some role in an understanding of BD.

Methods

Sampling and Recruitment Procedures

Recruitment of participants. In line with general qualitative principles of purposeful recruitment, where participants are selected on a non-random basis, to enable the in-depth understanding of particular phenomena (Patton, 2002), IPA advocates the purposive sampling of small, relatively homogeneous groups (Smith & Osborn, 2003). In keeping with this, inclusion criteria for the current study specified that participants were male, and aged between 18 and 35 years. In view of evidence that body image concern may vary across the lifespan (e.g. Cash et al., 1986), the proposed age range was considered appropriate, in order to preserve some degree of homogeneity in the sample. Within this, attempts were made to recruit participants who would, on the basis of albeit limited research findings, perhaps be more likely to have experienced some degree of BD, and who would thus provide the richest accounts of male concern. The sample was therefore intended to include each of the following: gay men (see e.g. Berscheid et al., 1973; Williamson & Hartley, 1998), men who reported engagement in a range of sports including bodybuilding (see e.g. Blouin & Goldfield, 1995) and men of varying Body Mass Indices (BMI; see e.g. McCabe & Ricciardelli, 2001).

Following Ethics Committee approval (Appendix C), the study was advertised within the University through an electronic system and posters, which were put up in a range of academic departments (Appendix D). In order to facilitate the purposive sampling of participants meeting the criteria

described, posters were also distributed to the University fitness suite, and to attendants at a Lesbian, Gay, and Bisexual Society meeting. Potential participants were also made aware of the research by word of mouth.

Participants were given two questionnaires in order to obtain descriptive and demographic information. Participants were able to access and complete questionnaires independently, leaving their contact details only if they wished to take part in an interview, or register their interest with the researcher and complete the measures at the time of interview. In total, 14 participants were interviewed; of these, 8 were recruited opportunistically, 3 responded to adverts placed within the University fitness suite, 2 saw the study advertised on the University's electronic system, and 1 responded to a poster within the School of Psychology. Two participants completed questionnaires but did not leave contact details, 1 provided contact details but did not respond to an invitation to interview, and 2 completed questionnaires but were not followed up as a sufficient sample size had been reached.

Recruitment of interviewers. In addition to the principal (female) researcher, two male researchers were recruited to act as interviewers for the study. Seidman (1998) notes that interview data may be influenced by interviewer-interviewee gender difference. This is not contrary to an IPA perspective, which acknowledges the role of the social milieu in creating, to some extent, participants' stories; indeed, gender is likely to be only one of many factors, unique to each relationship, which will impact on the data. Thus, the inclusion of male interviewers was not an attempt to reduce interviewer gender bias per se. Rather, it was hoped that allowing

participants to choose, wherever possible, the gender of their interviewer, would facilitate open discussion around the personal and potentially sensitive issues that the study aimed to explore. The interviewers had some prior experience in qualitative interviewing and analysis techniques. Further training was provided in both general interview skills and issues relating to IPA. Summaries of the material covered within each training session are provided in Appendixes E and F, respectively. Training sessions were conducted by the principal researcher and were also attended by two supervising Clinical Psychologists.

Measures

Semi-structured interview. An interview schedule was constructed in accordance with guidelines appropriate to an IPA perspective (Smith, 1995; Smith & Osborn, 2003). Broad topics for discussion were guided initially by the literature, and aimed to address:

- How perceived societal ideals related to participants' own views
- The experience of body image concern (BD)
- Triggers to the experience of BD
- Consequences of the experience of BD

Within these broad domains, specific probes were included regarding participants' thoughts, feelings and behaviours. As recommended by Smith (1995), questions were ordered such that participants would be asked first

about their more general views, before being prompted about more sensitive and personal issues of concern. A final section, addressing participants' satisfaction with their body, was included in order that they would be less likely to end the interview in a state of distress. In view of the exploratory nature of the study, it was not presumed that the schedule would capture all issues considered relevant to participants. Thus, in accordance with the ethos of semi-structured interviewing (Oppenheim, 1992; Smith, 1995), it was intended that specific prompts would be followed when necessary, rather than prescriptively.

As suggested by Smith (1995), the content of the schedule was modified, and supplemented, in light of discussion with colleagues and with the other interviewing researchers. Within this, an initial assumption that the interviewer and interviewee would hold a shared understanding regarding the meaning of "body image" was identified. This was addressed by asking participants directly to describe their understanding of this term. A final addition to the schedule; regarding participants' understanding of factors underlying the development of their own ideals, was made following a review of initial interview data. This process is in keeping with an IPA perspective, in which initial interview responses may be used to inform further inquiry (Macran, Stiles, & Smith, 1999). A copy of the final interview schedule is shown in Appendix G.

Participant characteristics questionnaire. Participants each completed a Participant Characteristics Questionnaire (Appendix H) in order to gather descriptive information relating to age, sexuality and ethnicity, as well as

frequency of engagement in exercise, type of exercise, and a history of eating disorder, if relevant.

Eating Attitudes Test. Participants were administered the 26 item Eating Attitudes Test (EAT-26; Garner, Olmsted, Bohr, & Garfinkel, 1982). Items are scored on a 6-point scale ranging from *never to always*. Scores range from 0 to 3, with scores on each of the three choices representing the least psychopathological response being collapsed and given a score of 0, and the remaining three (*often, usually, always*) being assigned scores of 1, 2, and 3, respectively (with the exception of one reverse scored item). Item scores each contribute to one of the following subscales: Dieting, Bulimia and Food Preoccupation, and Oral Control. For the purposes of this study, only the total score was used. Garner et al. (1982) indicate that the measure is suitable for use as a screening tool in non-clinical samples, and propose a cut-off of 20 as indicative of disordered eating attitudes and behaviours. The EAT-26 has good validity (r = .79; Mintz & O'Halloran, 2000) as a measure of undifferentiated eating disorder, and a high level of internal reliability (α = .90; Garner et al., 1982). The EAT-26 also asks that participants report their current height and weight. Each participant's BMI (kg / m^2) was calculated from this information.

The Participants

Participant details considered relevant to the study are summarised here. Further detail regarding each participant is given in Appendix I.

Seven of the participants described themselves as heterosexual, 5 as homosexual, and 2 as bisexual. Participants had an age range of 18 to 32 years (M = 23.3, SD = 3.8). Their BMI scores (M = 25.0, SD = 4.8) ranged from 18.4 (underweight) to 34.1 (obese; World Health Organisation, 2004). Thirteen participants described themselves as white, and 1 as white/ middle eastern. Participants' total scores on the EAT-26 ranged from 1 to 33 (M = 6.7, SD = 8.3); only 1 participant's score fell above the clinical cut off. None of the participants had a history of eating disorder diagnosis. Two of the participants did not engage in any exercise; the remainder described engagement in a variety of activities including weight training, jogging, and football.

Data Collection

Participants were interviewed individually. Interviews took place at the University or at a location convenient to the participant, such as their own home. Interview duration ranged from 20 minutes to an hour. With participants' consent, all interviews were audio taped, and were transcribed verbatim for analysis. Nine interviews were conducted by the primary researcher. Three participants indicated a specific preference for a female researcher; the majority had no particular preference, and none requested a male. Pilot interviews were conducted by each researcher, and were examined by the principal researcher using criteria suggested by Larkin (2003), to ensure their quality. On this basis, these were considered suitable for inclusion in the subsequent analysis. Early interviews were also

examined, in order to inform further development of the interview schedule, as described previously.

Participants were given an information sheet (Appendix J) and signed a consent form (Appendix K). Participants completed the Participant Characteristics and EAT-26 questionnaires. Interviews were then conducted. Following completion, participants were given a debriefing sheet (Appendix L) and follow-up letter (Appendix M) providing information about sources of support, should these be necessary. Participants were asked for verbal consent to be contacted in the future to comment on the themes. This follow-up phase did not form part of the current study, but would be useful in evaluating the face validity of themes, prior to item generation. Participants were given the opportunity to ask questions and were each invited to write down any relevant information they had not felt comfortable disclosing verbally. No participants chose to do this. Interviewers were made aware of procedures to follow should participants appear distressed or disclose something of serious concern. The follow-up letter was considered sufficient in highlighting sources of possible support for any participant scoring highly on the EAT-26.

Given that IPA explicitly acknowledges the contribution of the researcher's own perspective in creating meaning from interview data (Smith, Jarman, & Osborn, 1999), interviewers each kept reflective accounts of their experience, over the course of the data collection period. Salient points from each of these are summarised in Appendix N.

Data Analysis

Analysis was conducted by the principal researcher, following the idiographic approach described by Smith and Osborn (2003). The sample size for the current study (N = 14) was considered large by IPA standards. For example, although IPA has been used as a methodology for samples of 15 participants (Smith & Osborn, 2003), sample size is commonly in the region of 5 to 10 (Smith, 2004). Smith (1995) outlines a methodology for working with larger samples, whereby the in-depth analysis of a subset of interviews provides the basis for analysis of the remaining transcripts. This procedure was followed in the current study.

Initial subset analysis. Four transcripts were selected for initial analysis; other than ensuring that one transcript per interviewer was included in this sample, selection was made on a random basis. Analysis was conducted in the following way: each transcript was read several times, and notes made in the left hand margin. As suggested by Smith and Osborn (2003), the notes constituted comments regarding anything in the text that was significant or meaningful to the researcher; on some occasions summarising the content of the text, and on others suggesting possible interpretations about its meaning. The preliminary notes were then translated into theme titles, which encapsulated their key meaning. These were written into the right hand margin of the transcripts. For each transcript, the full set of theme titles was examined together. Themes were reorganised on a conceptual basis, in order to reflect their relationship to one another. As highlighted by Smith and Osborn, it was important that this process was

iterative, with the more abstract theme concepts being checked against the original data, to ensure their accurate foundation in the text. To support this process, a list of verbatim excerpts illustrating each theme was compiled. In this way, a master list of theme titles and representative extracts was created for each of the initial four transcripts. The master list from one transcript is shown in Appendix O, as an example.

Further analysis. The master lists of the initial four interviews were examined together and an amalgamated list of themes and excerpts produced. Again, the themes were organised conceptually; the researcher attempted to identify similarities and differences across the themes, and consolidated themes were checked against the initial data. As suggested by Smith (1995), further analysis was conducted on the basis of this data. For each new transcript, extracts illustrating the existing themes were highlighted and listed with the themes as evidence. In keeping with Smith and Osborn (2003), it was also considered important to recognise new themes as they emerged. Analysis of the remaining ten transcripts was, therefore, conducted in two stages: initially, five further transcripts were analysed, and the master list updated with examples of both existing themes, and of each new emerging theme. The final five transcripts were then examined for instances of themes according to the modified master list. Again, the master list was updated with examples of existing and new themes. Finally, all earlier transcripts, including the initial subset, were re-reviewed in light of the most recent set of themes; illustrations of the new themes were added to the data set when they were identified. Thus, a final document was produced,

consisting of a master set of themes, organised conceptually, and supported by every relevant example from each of the transcripts.

Audit of analysis: verification and credibility. The process and results of analysis were audited at various stages. Following analysis of the first two transcripts and, again, following analysis of the initial subset, a section of text from one of the interviews was analysed by another researcher. In the first instance this was completed by a colleague with similar experience in IPA, and in the second, by one of the supervising researchers. In each case, the process by which themes were derived was discussed. IPA acknowledges the possibility of there being more than one legitimate interpretation of a participant's reality (Smith, 2003). However, inclusion of a second analyst at two time-points during the process of analysis, enabled the researcher to confirm that the procedure being followed was reasoned and systematic. Although not intended, therefore, as a measure of inter-rater reliability, it was noted (qualitatively) that there was considerable overlap between the themes identified by different analysts, at each stage.

In keeping with suggested good practice guidelines (Elliott, Fischer, & Rennie, 1999) the complete set of themes was examined by the male interviewing researchers. Neither had any further role in conducting the analysis. Again, the aim was not to establish the correctness of the account, per se, but rather to invite comments regarding its plausibility. The process by which themes were developed, including the movement towards more abstract concepts based on verbatim evidence, was considered credible. Finally, the reflective accounts (Appendix N) were examined alongside Smith's (1995) suggested guidelines. Whilst one interviewer acknowledged

how a mutual interest in exercise behaviours may have facilitated discussion around these issues, there was no indication that participants had been affected negatively by any aspect of interview style. Where, on one occasion, an interviewer felt that their own assumptions might have been leading, this was considered in the analysis, and any comments thought to have arisen directly as a result of this discounted.

Results

Participants' understanding of what should be included in a discussion of one's body image varied, reflecting the diversity within the literature. For example, whilst some men distinguished between body image and one's general "looks", others did not. Although it was noted during analysis that the men made reference to a wide range of physical attributes (e.g. hair, teeth, and complexion) in addition to body shape and weight, physical descriptors were not included in the master set of themes. This is in keeping with Smith and Osborn (2003), who argue that it is necessary to prioritise the themes. The exclusion of physical descriptors from the analysis was considered appropriate in view of the intended focus of the study, on experiential factors. Many participants included in their discussion reference to their more general fitness and health. These issues have been included in the following analysis, as far as they relate to the experience and communication of BD.

Analysis yielded 15 themes across 4 broad domains (societal, interpersonal, intrapersonal, and social presentation), indicating that body image, and dissatisfaction with one's body image were experienced not only

on a personal level, but within a societal, and interpersonal context. In addition, themes arose that were considered a function of how the men chose to present themselves. Themes from each domain are presented here, and are illustrated with verbatim extracts from the transcripts (italicised). Some transcript conventions, and interviewer interjections have been omitted for clarity. Further detail is given in Appendix P, regarding each participant's specific contribution to the themes and their constituent sub-themes. Participant names have been changed, in order to maintain anonymity.

Societal Domain

Societal ideals acted as the backdrop against which the men experienced their own bodies. It is the aim of this account to bring the phenomenological experience of the men to the fore; thus while societal ideals emerged as a theme in the data, less attention is given to the specific nature of these ideals than to their impact on men's perception of themselves. Participants' accounts revealed a central tension; traditional societal values, wherein male body image concern was deemed undesirable, were in conflict with the increasing pressure men felt to conform to prescribed societal norms and ideals. Thus, the participants appeared to find themselves caught in a changing climate: An increasing emphasis on male body image appeared to be related to broader changes in the male gender role, while the social acceptability of concern appeared to vary across different groups.

Theme 1: Societal norms. The majority of men acknowledged the existence of societal ideals. Within this, however, tension existed regarding the extent to which such ideals were shared, or diverse. Variation was thought to occur across time, cultures, and societal subgroups. There was also conflict regarding whether such norms were a product of what one is exposed to, in terms of individual experience, group norms, and the media, or were a representation of some enduring physical qualities related to evolution and survival of the fittest. Essentially, the men presented both sides of a nature/ nurture debate. For example:

I think it's developed from prehistoric times… looking good and being dominant in the pack (Liam)

versus

People are drawn towards liking certain types of body because of their exposure to it (Michael)

Theme 2: Unacceptability of body image concern. The majority of participants indicated that BD held some negative connotations for themselves, or for men in general. In some cases this was expressed directly:

They don't want to be seen to be weak by admitting that they don't feel very happy with themselves (Dominic)

In other cases, negative connotations were apparent in participants' descriptions of men considered to be strongly invested in their appearance:

I think most people look at erm, for example bodybuilders or something like that... as being a bit of a joke... as not being real (Derek)

Acceptability of concern with one's body appeared to vary across groups, being more permissible, for example, within the gay community:

It's more crystallised in homosexual relationships, because there is the obsession with appearance... and body, like image (Ben)

However, several participants also described a more general shift in society, towards a growing emphasis on male appearance:

I think the image is, is important, and is becoming increasingly important with, you know, the amount of bombardment you get from the media, everyone in the media looks perfect (Dominic)

Some participants noted a general change in the male gender role:

You're not allowed to be too forceful, or er, or even erm (PAUSE) act as if women need any help, like opening doors is frowned upon now (Paul)

Others linked this more directly to increases in male body image concern:

What's been female in the past ... I think the tables are turning, definitely (Ben)

Theme 3: Pressure to be perfect. Whilst any expression of dissatisfaction with one's body was frequently disallowed, some participants described feeling a pressure to conform to societal ideals. For example, in relation to being overweight, one participant noted:

What is disheartening, is that no-one thinks that I <u>should</u> be happy (Tom)

Several participants felt that appearance was critical to whether one was accepted in society. For example:

I think it is important in, in the world, it is important to be nice looking because people, you know, if you're not nice looking, people, I don't know, because people don't like it, do they? (Anthony)

Although a strong investment in one's appearance was typically not considered acceptable, there were also negative connotations of not meeting ideals, which extended beyond appearance per se, to assumptions about people's character:

I think if you're excessively fat, or, I think it shows a lack of, you know, self-control (Nick)

Interpersonal Domain

How one is perceived by others was central to participants' definition of body image. Appearance seemed to function as a means of communicating with others, while the feedback one receives from others is, apparently, critical in determining satisfaction. Thus, BD was not experienced in a social vacuum but, rather, depended upon interaction with others in order to exist.

Theme 4: Body image as an interpersonal construct. When asked to define body image, many participants described the perceptual, cognitive, and affective dimensions suggested by the literature (e.g. Thompson, 1990). Less expected, however, was the idea that these dimensions appeared to operate primarily in an interpersonal context. Within their definitions, the majority of participants gave some mention to how they were perceived by others. For example:

The way I look, um, or the way, and the way I feel I look, and the way other people, I feel other people look at me… what I think, and then what I, what I'm thinking other people are thinking of me (Oliver)

In many accounts, the way in which participants felt they appeared to others assumed a central importance:

A friend of mine's got really short biceps and even th-, even though he's weaker than me on, on curls and bicep exercises they look better because, because of that (Paul)

Theme 5: Communicative function of appearance. The significance of external appearance seemed to lie in what it is able to communicate about a person. A number of participants associated good looks, generally, with a particular lifestyle and attributes:

Ideal male image, someone very muscular, probably muscular, fit, um, (PAUSE), er, successful financially, confident and outgoing (Gareth)

Many accounts indicated that appearance communicated something about one's masculinity. This was considered in relation to one's strength and prowess:

Defined hard lines are another extension of that, looking ready for action… looking like you can take a beating (Paul)

and in relation to one's genetic viability:

I think, obviously that's what women look at in men… shows they can be strong and can look after them and be protective, shows they're quite fit, um, healthy, give them good babies (Anthony)

Theme 6: Interpersonal influences on BD. In addition to its communicative function, one's appearance to others was deemed central by participants in determining how they felt about themselves. Feedback from others in the form of comments could have a significant impact:

Those words stick in my head (Oliver)

For some participants, simply being seen by others was sufficient to elicit concern:

I think what, what do people look at me and think… what are their perceptions of me, do they think "oh he's really lazy, he doesn't go to the gym" (Ben)

Feedback from sexual partners was particularly salient. Affirmation from a sexual partner was powerful in alleviating distress:

I have a girlfriend now… that has helped me not care about the things I can do nothing about (Paul)

In contrast, sexual rejection was often identified as a trigger for concern:

I'm not completely happy with my body… so when I go out on the scene looking for someone… and then coming home alone, it is very disheartening (Tom)

Other people could also play a role in causing distress by acting as objects of comparison. Participants described comparing themselves with both peers:

I just usually see people erm, a-, who I think look better than I do, and yeah, that can be… depressing (Lewis)

and with media ideals:

I could never be as beautiful as that for example, um, you know, like men in magazines (Mark)

For gay men, interpersonal factors could be particularly significant. Some participants described how, in a same-sex interaction, one could simultaneously experience both sexual rejection, and unfavourable comparison:

Speaking as a gay man, I find it double-sided, because obviously, you know, you look at it and think "oh he's attractive… but he'd never look at me in a million years", but also, sometimes you might think "he's attractive, but I'd never look like that in a million years either" (Derek)

Interpersonal factors were significant not only in influencing the men's satisfaction with their bodies, but in determining the importance of BD. Thus, in the absence of social contact, BD per se was not always sufficient to elicit behavioural change:

I'll think "oh I can sort that out tomorrow", but that's only, that's only when I'm in like a secure place, as in I'm not in, sort of on display (Oliver)

Intrapersonal Domain

On an intrapersonal level, body image was considered important as a source of self-esteem. Dissatisfaction was experienced on both emotional and cognitive levels, and was also described by one participant in somatic terms. Several of the participants described their dissatisfaction in terms of a discrepancy between perceived ideals and their actual selves. Whilst a range of intrapersonal factors were seen to influence BD, including cognitive style and mood, the notion of discrepancy was critical. Events that served either to magnify or minimise one's perceived discrepancy were noted by many to have an effect on their level of BD. Participants described a range of strategies for managing BD, each of which had the effect of either reducing or enabling them to tolerate discrepancy. Finally, control emerged as an important issue.

Theme 7: Importance of body image to the self. Several of the participants highlighted body image as a source of self-esteem. Body image was linked to how participants felt about themselves:

It makes me feel comfortable, more comfortable with myself actually... and it makes me feel more confident (Dominic)

It was also identified as a life-domain in which one could achieve:

I remember at school thinking, "well, if I'm going to fail at school, then I might as well have a good body" so… it's kind of something to have, you know, hope in a way, erm yeah, so you know, even if I was rejected by everyone, you know, at least I'd think "well, I've got my fitness" (Mark)

From Mark's account it seems likely that body image would assume greater importance when other aspects of one's life are unsatisfactory. In line with this, one participant noted:

It just depends on whether or not you have other things in your life (Ben)

Theme 8: The personal experience of BD. The majority of participants identified an emotional level to BD, although the type and degree of emotion described varied considerably.

That makes me feel awful, and I just… it really, really upsets me (Oliver)

Apart from nostalgia, um, I don't feel terribly bad about it (Steven)

Many participants highlighted cognition as another aspect of BD:

I just get kind of negative thought (sic) now and then (Mark)

One participant described BD as a somatic experience:

It is like a physical feeling, like having it there, and knowing it's there, erm, you know, sitting down, lying down, whatever it is, and erm, having this thing there (Lewis)

At a broader level, several of the participants linked the experience of BD to awareness of discrepancy between their actual selves, and personal ideals:

If I think that I'm (PAUSE) too thin, then it's because I imagine that an ideal body is not as thin as mine (Michael)

Theme 9: Intrapersonal influences on BD. Simply seeing oneself was highlighted by the majority of participants as a trigger to BD. As one participant put it:

I'm not particularly thinking of how I look, but if I catch sight of myself in the mirror or something, then I'm forced, literally, to reflect (Michael)

Once engaged in this process of reflection, cognition appeared to play a role in maintaining distress. Cognitive distortions were apparent in several participants' accounts. A number of men described a selective or exaggerated focus on their perceived flaws:

If I smile, and I look at a photo, all I can see is my two like incisors, huge on the photograph… and if it's a side profile, all I can see is the back of my head… and I don't look at anything else, I just look at those two things (Oliver)

Relatedly, others discounted any evidence contrary to what they perceived, maintaining their conviction in the negative:

Family say "oh no, no, it looks fine" and stuff like that, but still, it's still what I, you know, what I feel, I see and I feel (Lewis)

Again, at a cognitive level, several participants described themselves as more convinced by what they *felt*, rather than what they *knew* to be true. For example:

I was feeling like my (PAUSE) probably wasn't happening, but it was feeling as if my muscles were probably wasting away (Mark)

Mood appeared to have a moderating influence on BD. The potency of triggers to BD varied according to participants' emotional state. With regard to seeing himself, one participant explained:

It can either be, I can either be feeling positive, and that's a negative, and they cancel each other out, so I just go "well ha, I don't care"… erm, or I can,

you know, I can see it, or be maybe just unhappy anyway, and see it and feel more unhappy (Lewis)

Seeing oneself, and focusing selectively on one's perceived flaws each increases awareness of how discrepant one is, from one's own ideals. In keeping with this, the majority of participants gave examples of events where this discrepancy was highlighted, as triggers to BD. Trying on clothes in shops was a particularly common example:

Ooh, God, shopping, like… buying clothes… and thinking "God, I would look really good in that if I had big arms… if you can't fit into something, or can't fill something (Ben)

Accordingly, events that reduced participants' perceived discrepancy had the effect of alleviating concern:

It's quite positive, I kind of feel like, if I've been to the gym, and then I watch the pop video I think, then I'm, now I look, now I look more like you (Dominic)

Theme 10: Management of BD - reducing discrepancy. Perceived discrepancy between oneself and one's ideals appeared to be key. Participants attempted to reduce the discrepancy between themselves and their ideals in a number of ways, which resulted either in participants bringing themselves closer to existing ideals, or bringing the ideals closer to themselves. Nearly all of the participants had engaged in behaviours to

modify their own appearance. Many described specific formulae or rules that they followed:

I tend to go to the gym um (PAUSE), every, every night, or at least every other night, and work hard, erm, and that includes eating healthily as well, three meals a day, a salad at lunchtime, um, a main meal with a starter in the evening and er, a cereal breakfast in the morning (Liam)

For some participants, the extent of their dissatisfaction was reflected in the sacrifices they were willing to make:

It's kind of an internal struggle almost, um, in as much that I enjoy eating very much (Lewis)

Several of the participants described attempts at disguising their perceived flaws, or used particular strategies to prevent their discrepant features from being seen:

I hold my hands in front of my face… or if I smile, like I say, I won't open my mouth and stuff (Oliver)

Others avoided certain activities altogether:

I don't tend to swim very much... because obviously, being a bit wobbly and a bit, you know, sort of like, erm not, because you can't wear very much when you swim (Derek)

Several of the participants described attempts to emphasise their non-discrepant features, as a means of compensating for perceived flaws:

I'd like to have a bigger build, but I've kind of got by on my face a bit more... so I worry more about how my face looks than my body (Ben)

Rather than, or sometimes in addition to, changing themselves, participants also tackled discrepancy at the level of ideals. Some men explicitly rejected or derogated societal norms:

I don't think there should be an ideal (Tom)

I don't think being able to lift kind of a bench press, how ever many pounds really, is either here nor there really (Nick)

Reducing the validity, or appeal, of societal values appeared to function as a means of minimising the distress associated with not meeting these values. Several men allied themselves with alternative ideals, which were in each case more compatible with their existing body type, and thus more attainable. In keeping with this, a number of men rated health as more important than appearance. This can be interpreted as a strategy that

enabled the men to justify their discrepancy from more commonly endorsed societal ideals:

Being overweight, you can still be healthy… I think healthier would be, should be sort of the more important factor than, than looking ripped or whatever (Lewis)

One participant described how his body, although discrepant from societal norms, was in keeping with the alternative ideal he had chosen:

I was always quite, quite thin… but… if you're into a particular sport it gives you a lot of security actually, and you can say well hey, the way I look is because it's, it's compatible with the sport I'm in, I'm good at it and therefore, therefore I'm actually quite happy with the way I look (Nick)

Many participants chose to emphasise the importance of non-physical ideals, and to ally themselves with these:

Because I like myself as a person… I accept the physical that goes with it (Derek)

Theme 11: Management of BD – tolerating discrepancy. Affiliating themselves with an alternative, attainable ideal allowed some men to eliminate or reduce any discrepancy between themselves and their ideal. Other strategies were evident in the participants' accounts. These were

interpreted as enabling men to tolerate, manage, or accept any such discrepancy or its associated affect. Many participants normalised their own discrepancy, by drawing comparisons with others who were similarly or more discrepant, thus reducing the significance of their own perceived inadequacies. For example:

I think yeah well, I'm still a lot better, er still got a lot better body than ninety percent of men out there (Paul)

The attributions men made regarding their discrepancy from the ideal also appeared to influence their ability to cope. Several men attributed their inability to meet certain standards to the practicability of the ideals, rather than to themselves:

You'd have to take steroids and things like that, to get erm, that sort of muscular (Mark)

In addition, the majority of men made some attribution about their own inability to control or change their perceived flaws. Some were explicit in linking this to their capacity to cope:

If I could change I would, I can't, so I'm not really bothered (Gareth)

A number of participants described acceptance of their bodies as a process of adjustment that had occurred over time:

You learn to live with it, when I was younger it was more of a big deal. The other thing as well is, um, as you get older you do accept yourself (Derek)

As described earlier, the men identified an emotional component to BD. Perceived discrepancy from one's ideals has been highlighted as a key element of BD and, therefore, in eliciting distress. Thus, management of this discrepancy involves management of associated emotional distress. A number of strategies for coping with emotion were evident in the participants' accounts. Two men described themselves as withdrawing from difficult situations, and engaging in emotionally soothing activity. For example:

I'm just thinking, I don't want to be here anymore, just want to go home... just go home, and sleep it, you know sleep it off (Lewis)

A number of men made light of their feelings, in order to minimise distress. For example, in relation to teasing by others, one participant explained:

At first it upset me a little bit, but then I thought it doesn't matter, and you know, I'll laugh along with them and then, then I don't mind at all (Anthony)

A few managed the experience of BD by interpreting their affect as positive:

I don't think I am depressed about it... it'd make me feel sort of motivated I suppose (Mark)

One man appeared to cope by directing his affect outwardly in the form of anger, rather than at himself:

Maybe I should blame myself a little bit, like if I was thinner, it w-, I w-, it wouldn't happen so often, and that, that's just fact I guess, but now, I think it's entirely the shop's fault, because they... should cater for larger sizes, and I hate that they don't (Tom)

In a broader sense, many of the men took a non-emotional, practical approach to the management of their bodies. This is reflected in the terminology they use, and may have enabled them to distance themselves from distress:

If you liked a car, for example, you like it, but you could still improve it, so... it's the same as my body really (Mark)

Theme 12: Control. As described previously, the men appeared to make attributions of no control in order to cope with their perceived flaws; there is nothing they can do to change it, so why worry? On the other hand, a lack of control, or potential for change appeared to function negatively for several of the men, engendering hopelessness in some cases:

I've done a lot of work in the gym, um, done all I can, but I still can't change these genetic things... so just, it just kind of erm, seems a bit pointless (Paul)

Perhaps as a means of coping with this, the men often made attributions that they were able to effect change:

It's all something that I can control, so I don't worry (Liam)

Interestingly, some of the men using "no control" attributions in order to cope with some perceived discrepancies were also those making "can control" statements about others. Each of these strategies appeared to alleviate distress, in different ways. Indeed, two of the men made attributions both of control and of no control about the same physical feature. Neither of the men explicitly acknowledged this conflict; doing so would likely have rendered one set of attributions untenable, and thus of no further use as a means of coping.

Social Presentation Domain

The overarching societal tension, whereby men are expected to conform to physical ideals yet at the same time to invest little concern in their appearance, had an influence on how the men presented themselves. Affiliation with ideals other than appearance was interpreted as an intrapersonal coping strategy; reducing one's discrepancy from societal norms. This, alongside more direct denial of concern with one's appearance, however, seemed to serve an additional function of enabling the men to portray themselves in a certain way.

Theme 13: Aim to be average. In light of negative connotations associated with either failing to meet, or exceeding normative standards, some of the men appeared loath to stand out, striving instead to be average:

I'm not really fat, I'm not really thin, I think that's healthy really, to be in the middle somewhere (Anthony)

Theme 14: Concern with function, not appearance. Several of the men took care to emphasise enjoyment and health as reasons for their engagement in exercise. Similarly, when they did express interest in or concern about their appearance, many of the men were keen to relate this to the functional ability or health of their bodies, rather than to aesthetics. In addition to reducing their own perceived discrepancy, this enabled them to comply with societal notions that concern with one's appearance, per se, was unacceptable.

I thought "oh, that's, that's quite bad", but erm but again as I say, it's from a, I, it's from a health perception… rather than what I look like (Nick)

Theme 15: Denial and minimisation. Denial was a central theme; although the majority of participants had engaged in some form of behaviour to change their appearance, most were keen to minimise the emotional impact of their concerns, and their interest in the subject in general:

I can't say that I think about it too much (Steven)

I don't worry about it... It doesn't, doesn't bother me, erm. No, I, really, it doesn't... worry me (Ben)

In addition to the explicit denial of emotion, there was incongruence in many of the men's accounts, between the content of their speech, and the manner in which it was expressed:

Put on loads of weight and then generally spiralled down into depression, quite badly (laughs) (Tom)

This was interpreted as a further means of emotional denial or distancing, which may have functioned as a form of coping for the men, but also enabled them to minimise the extent of their concern within the interview context. Some men appeared to have difficulty in using emotional language more generally, for example, in identifying and naming emotions:

Tired's not the right word, but it's close (Paul)

In line with not wanting to appear over-invested, the majority of participants were also careful to minimise their acknowledgement of positive traits, perhaps in order not to appear vain:

I'm quite happy with my face... um (PAUSE) not because I think it's particularly nice or anything else like that (Derek)

In addition, many of the men rigorously denied engagement in excessive, or driven behaviours:

There's periods when I don't exercise, I'm not an exercise freak (Steven)

In some cases this was in direct contrast to the behaviours described. For example, Paul stated both that:

I don't let it take over my life

and

I wouldn't be able to stop lifting weights even if the doctor said I had to

Thus, even when engagement in body change behaviours was of considerable importance to the men, many were keen that this did not appear to be the case to others.

Discussion

Summary of Findings

The experience of BD was described in cognitive, behavioural and affective terms, and was frequently conceptualised as the extent to which the men perceived themselves to be discrepant from their ideals. Consequently,

mechanisms, by which BD was managed, appeared to function by reducing the magnitude or significance of such discrepancy. Body image was highlighted as significant to self-esteem and, also important, was what it communicated to others. Accordingly, BD was not only experienced at an intrapersonal level. Instead, the salience of perceived discrepancy appeared to depend upon its social context.

Conflict and tension arose as over-arching themes in the analysis. Indeed, a number of themes were identified on the basis of incongruence between ideas expressed by the men. For example, many men explicitly denied concern about their appearance. This is perhaps unsurprising, given the negative connotations of appearance concern apparently held at a societal level. However, denial of concern was juxtaposed by evidence of concern. For example, many of the men described engaging in behaviours to disguise or modify their appearance. Such behaviours are in keeping with the societal pressure to conform to ideals, described by the men. Aiming to be "average" was perhaps a means of resolving this tension. Further conflict was apparent between notions such as control versus no control, and acceptance of one's appearance versus change.

Relationship of Themes to the Literature

The literature has drawn on a number of theories to explain the development and maintenance of BD. Among these are cognitive behavioural, self-discrepancy, and sociocultural frameworks. Cognitive behavioural theory (e.g. Cash, 2002) posits that the activation of appearance-

related schemas triggers the experience of BD in terms of negative thoughts and affect, and this in turn prompts the use of cognitive and behavioural coping strategies. Self-discrepancy theory (Higgins, 1987) predicts that perceived incongruence between one's "actual" and one's "ideal" (i.e. what one would like to be) or "ought" (i.e. what one feels one should be) self will engender negative affect. A number of researchers have drawn on this perspective in relation to BD. For example, the BIQ (Cash & Szymanski, 1995; Szymanski & Cash, 1995) assesses respondents' self-ideal discrepancies on a range of physical attributes. Self-discrepancy theory is not inconsistent with sociocultural models (e.g. Stice, 2002), which suggest that societal norms may be internalised as personal ideals. In addition, sociocultural theories highlight comparison with others, as well as the observation of dissatisfied behaviour by others, as significant in engendering distress. Whilst, in approaching the study, the researcher acknowledged a broad affiliation with cognitive behavioural principles, the emerging themes were consistent, to some degree, with each of these models and suggested substantial overlap between their respective processes. Examination of the themes, therefore, led to a wider understanding of BD, in which cognitive behavioural mechanisms had some influence, but did not play an exclusive role.

The men described cognitive, affective, and behavioural components to their experience of BD. However, these elements appeared to operate primarily in a social context; triggers to the cognitive, and affective experience of BD were commonly interpersonal in nature. Moreover, this cognitive behavioural perspective was not divorced from the notion of self-

discrepancy. For example, certain types of cognitive distortion served to magnify a perceived discrepancy, while cognitive and behavioural outcomes of BD often served to reduce its magnitude. Alongside this, sociocultural factors, such as comparison with media ideals and with similarly discrepant peers, served to highlight or minimise the men's own discrepancy, respectively.

Higgins (1987) argues that the discomfort associated with self-discrepancies relies not only on their existence (i.e. availability), but varies also according to their accessibility. This is, in turn, dependent on their activation by salient cues. In line with this, the influences on BD described by the men commonly related to factors that brought discrepancy into awareness. The existence of discrepancy, per se, was not always sufficient to elicit behavioural change in the absence of a social context. Rather, distress appeared to vary according to factors such as sexual affirmation and participants' mood state, and did not present as an enduring trait. Whilst the notion of situationally-dependent affect associated with BD has been addressed by the SIBID (Cash, 1994), current measures of self-discrepancy in relation to BD, such as the BIQ (Cash & Szymanski, 1995; Szymanski & Cash, 1995), do not take such contextual variation into account.

Rejection or modification of ideals by the men was interpreted as a means of reducing self-ideal discrepancy. This is contrary to a traditional self-discrepancy perspective, in which Higgins (1987) argues that ideals, or "self-guides" are representative of internalised parental standards, and that modification of these is resisted. Self-guides relating specifically to one's appearance may be more likely to represent an internalisation of societal

standards than parental views; these may be more accessible to change. Certainly, the men more commonly made reference to ideals presented in the media than within a family context.

Existing literature concerning the ways in which men may reduce their perceived self-discrepancies, has often focused on attempts to modify body shape (e.g. Mishkind et al., 1986). A focus within the literature on body change behaviours is justified given the ramifications for health associated with dieting and excessive exercise. However, within the current study such behaviours constituted only one set of a range of strategies, which had the effect of reducing discrepancy. For example, comparison with others was interpreted as a strategy used by the men to normalise their own discrepancy. Social comparison, alongside the avoidance and camouflage behaviours described by several of the men, may serve to maintain preoccupation and thus trigger further distress. Certainly, avoidance and camouflage have been highlighted as factors contributing to the maintenance of body dysmorphic disorder (Veale et al., 1996). Thus, an emphasis on the wider aspects of cognitive and behavioural responses to BD may be warranted in the literature.

Limitations and Implications of the Findings

The extent to which findings from the current study may be generalised is undoubtedly limited; the sample was non-representative, consisting of men within a specified age-range, who were predominantly white and often highly educated. Moreover, participants were men who chose

to contribute towards a discussion of BD; they may have differed systematically from men who did not take part. These issues are not unexpected. The methodology chosen for the present investigation was consonant with the aim of in-depth exploration, rather than widespread generalisation. Furthermore, that a group of men who opted into a discussion regarding body image concern should have so frequently denied the existence of concern, adds further weight to the theme of denial. However, the limited nature of the sample does have implications for the application of findings. Whilst the themes may resonate with a broader group of men than that included in the sample, they are unlikely comprehensively to capture the concerns and experience of all men. For example, societal pressures were thought to play a role in moulding the experience of men in this study. Men living in different cultures and societies may well face different experiences. Finally, IPA acknowledges the subjective nature of interpretation. However, the inclusion of a data audit, and the concordance of both unprompted participant feedback and interviewer reflections with the content of certain themes (Appendix N) increased the likelihood that the interpretations were valid.

Notwithstanding these limitations, if one considers the possibility that societal pressures noted in this study may apply to a wider population, men should be considered vulnerable to the development of BD. The men in this study were, apparently, under increasing pressure to conform to certain ideals, yet were at the same time seemingly uncomfortable in expressing appearance-related concerns. An increasing societal emphasis towards appearance may increase the prevalence of BD, while denial and

minimisation of such concern by men is likely to impact on the detection of those at risk. Findings in the current literature that BD is typically more common among gay men (e.g. Williamson & Hartley, 1998) and among women (e.g. Berscheid et al., 1973) than among heterosexual males may be influenced to some extent by the willingness of individuals, within different groups, to disclose such concerns.

There is often an assumption that men may prefer to discuss their concerns with other men: for example Andersen (1999) suggests that it may be helpful for males diagnosed with eating disorders to engage with a male therapist. Within the current study male participants only ever indicated preference for a female interviewer. Whilst it is certainly appropriate that male clients are offered choice, wherever possible, regarding the preferred gender of their therapist, the findings from this study indicate that a same-sex preference should not be assumed.

That men may have difficulty in acknowledging appearance-related concern has been noted by existing literature (e.g. Mishkind et al., 1986). In line with this, some participants fed back, directly, a difficulty in discussing these issues (Appendix N). This holds implications for the assessment of BD in men. This study aimed to explore the phenomenon of BD in men, acting as the first phase in the development of an assessment tool. Difficulty in expressing concerns related to BD, and in discussing emotion more generally, are likely to complicate the measurement of BD in men. Further work towards the development of a measure based on these interview data should be informed by this, for example by taking special care to normalise concern.

In view of the focus within the current study on experiential factors, attempts were not made to inventory the specific bodily foci of male concern. Whilst the existing data could be re-examined for this purpose, the understanding afforded by the current analysis suggests that the process of BD is more important than the nature of the concern itself. Indeed, there are a number of existing inventories (e.g. the Body Areas Satisfaction Scale of the MBSRQ; Brown, Cash, & Mikulka, 1990, Cash, 2000; The Body Cathexis Scale; Secord & Jourard, 1953) which allow men to rate their (dis)satisfaction with a range of attributes. What this study adds to the literature base is an understanding of the experience of these concerns, and of the ways in which these are managed. Moreover, although participants in the current study reported a wide range of bodily concerns, there was commonality in the broad processes by which these concerns were triggered, experienced and dealt with. Thus, there may be more utility in a questionnaire measure that addresses these generic issues, rather than replicating existing inventory tools. In order to develop such a questionnaire, further work is required to generate specific items that tap into the themes highlighted in the current study. These may then be pilot tested within a larger, more representative group of men, and their psychometric properties established.

References

Andersen, A. E. (1999). Eating disorders in gay males. *Psychiatric Annals, 29(4),* 206-212.

Berscheid, E., Walster, E., & Bohrnstedt, G. (1973). The happy American body: A survey report. *Psychology Today, 7,* 119-131.

Blouin, A. G., & Goldfield, G. S. (1995). Body image and steroid use in male bodybuilders. *International Journal of Eating Disorders, 18,* 159-165.

Brown, T. A., Cash, T. F., & Mikulka, P. J. (1990). Attitudinal body-image assessment: Factor analysis of the Body-self Relations Questionnaire. *Journal of Personality Assessment, 55,* 135-144.

Carr, A. T. (2002). Body shame: Issues of assessment and measurement. In P. Gilbert & J. Miles (Eds.), *Body shame: Conceptualisation, research and treatment* (pp. 90-102). NY: Brunner-Routledge.

Carr, T., Harris, D., & James, C. (2000). The Derriford Appearance Scale (DAS-59): A new scale to measure individual responses to living with problems of appearance. *British Journal of Health Psychology, 5,* 201-215.

Cash, T. F. (1994). The Situational Inventory of Body-image Dysphoria: Contextual assessment of a negative body image. *The Behavior Therapist, 17,* 133-134.

Cash, T. F. (2000). *The Multidimensional Body-Self Relations Questionnaire: Users' Manual.* (3rd Revision) [Online]. Available from http://www.body-images.com

Cash, T. F. (2002). The Situational Inventory of Body-image Dysphoria:

Psychometric evidence and development of a short form. *International Journal of Eating Disorders, 32,* 362-266.

Cash, T. F., & Deagle, E. A. (1997). The nature and extent of body-image disturbances in anorexia nervosa and bulimia nervosa: A meta-analysis. *International Journal of Eating Disorders, 22,* 107-125.

Cash, T. F., & Labarge, A. S. (1996). Development of the Appearance Schemas Inventory: A new cognitive body-image assessment. *Cognitive Therapy and Research, 20(1),* 37-50.

Cash, T. F., Melnyk, S. E., & Hrabosky, J. I. (2004). The assessment of body image investment: An extensive revision of the Appearance Schemas Inventory. *International Journal of Eating Disorders, 35,* 305-316.

Cash, T. F., & Szymanski, M. L. (1995). The development and validation of the Body-Image Ideals Questionnaire. *Journal of Personality Assessment, 64(3),* 466-477.

Cash, T. F., Winstead, B. A., & Janda, L. A. (1985). Your body, yourself: A reader survey. *Psychology Today, 19(7),* 22-26.

Cash, T. F., Winstead, B. A., & Janda, L. H. (1986). Body image survey report: The great American shape-up. *Psychology Today, 20(4),* 30-37.

Cohane, G. H., & Pope, H. G., Jr., (2001). Body image in boys: A review of the literature. *International Journal of Eating Disorders, 29,* 373-379.

Cooper, P. J., Taylor, M. J., Cooper, Z., & Fairburn, C. G. (1987). The development and validation of the Body Shape Questionnaire. *International Journal of Eating Disorders, 6(4),* 485-494.

Drewnowski, A., & Yee, D. K. (1987). Men and body image: Are males

satisfied with their body weight? *Psychosomatic Medicine, 49,* 626-634.

Edwards, S., & Launder, C. (2000) Investigating muscularity concerns in male body image: Development of the Swansea Muscularity Attitudes Questionnaire. *International Journal of eating Disorders, 28,* 120-124.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38,* 215-229.

Fallon, A. E., & Rozin, P. (1985). Sex differences in perceptions of desirable body shape. *Journal of Abnormal Psychology, 94(1),* 102-105.

Franzoi, S. L., & Shields, S. A. (1984). The Body Esteem Scale: Multidimensional structure and sex differences in a college population. *Journal of Personality Assessment, 48,* 173-178.

Furnham, A., & Calnan, A. (1998). Eating disturbance, self-esteem, reasons for exercising and body weight dissatisfaction in adolescent males. *European Eating Disorders Review, 6,* 58-72.

Garner, D. M. (1997). *The 1997 body image survey results.* Retrieved January 10, 2003, from http://www.psychologytoday.com/htdocs/prod/ptoarticle/pto-19970201-000023.asp

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The Eating Attitudes Test: Psychometric features and clinical correlates. *Psychological Medicine, 12,* 871-878.

Garner, D. M., Olmsted, M. P., & Polivy, J. (1983). Development and

validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of eating Disorders, 2,* 15-34.

Higgins, E. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological Review, 94(3),* 319-340.

Hildebrandt, T., Langenbucher, J., & Schlundt, D. G. (2004). Muscularity concerns among men: Development of attitudinal and perceptual measures. *Body Image, 1,* 169-181.

Labre, M. P. (2002). Adolescent boys and the muscular male body ideal. *Journal of Adolescent Health, 30,* 233-242.

Larkin, M. (2003, June). *Interpretative phenomenological analysis.* Introductory workshop material provided at the 5th Annual IPA Conference, University of Plymouth, UK.

Macran, S., Stiles, W. B., & Smith, J. A. (1999). How does personal therapy affect therapists' practice? *Journal of Counseling Psychology, 46(4),* 419-431.

McCabe, M. P., & Ricciardelli, L. A. (2001). Body image and body change techniques among young adolescent boys. *European Eating Disorders review, 9,* 335-347.

Mintz, L., & O'Halloran, S. E. (2000). The Eating Attitudes Test: Validation with DSM-IV eating disorder criteria. *Journal of Personality Assessment, 74,* 489-503.

Mishkind, M. E., Rodin, J., Silberstein, L. R., & Striegel-Moore, R. H. (1986). The embodiment of masculinity. *American Behavioral Scientist, 29(5),* 545-562.

Oppenheim, A. N. (1992). *Questionnaire design, interviewing and attitude measurement.* (2nd ed.). London, UK: Pinter.

Patton, M. Q. (2002). *Qualitative research and evaluation methods.* (3rd ed.). London, UK: Sage.

Pope, H. G., Jr., Gruber, A. J., Mangweth, B., Bureau, B., de Col, C., Jouvent., R., et al. (2000) Body image perception among men in three countries. *American Journal of Psychiatry, 157,* 1297-1301.

Reas, D. L., Whisenhunt, B. L., Netemeyer, R., & Williamson, D. A. (2002). Development of the Body Checking Questionnaire: A self-report measure of body checking behaviours. *International Journal of Eating Disorders, 31,* 324-333.

Rosen, J. C., Srebnik, D., Saltzberg, E., & Wendt, S. (1991). Development of a body image avoidance questionnaire. *Psychological Assessment, 3,* 32-37.

Secord, P. F., & Jourard, S. M. (1953). The appraisal of body-cathexis: Body cathexis and the self. *Journal of Consulting Psychology, 17,* 343-347.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences.* (2nd ed.). NY: Teachers College.

Shafran, R., & Fairburn, C. G. (2002). A new ecologically valid method to assess body size estimation and body size dissatisfaction. *International Journal of Eating Disorders, 32,* 458-465.

Skrzypek, S., Wehmeier, P. M., & Remschmidt, H. (2001). Body image

assessment using body size estimation in recent studies on anorexia nervosa. A brief review. *European Child and Adolescent Psychiatry, 10,* 215-221.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking methods in psychology* (pp. 9-26). London, UK: Sage.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,* 261-271.

Smith, J. A. (2003). Validity and qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 232-235). London, UK: Sage.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1,* 39-54.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In Murray, M., & Chamberlain, K. (Eds.), *Qualitative health psychology: Theories and methods* (pp. 218-240). London, UK: Sage.

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51-80). London, UK: Sage.

Spangler, D. L., & Stice, E. (2001). Validation of the Beliefs About Appearance Scale. *Cognitive Therapy and Research, 25(6),* 813-827.

Stice, E. (2002). Sociocultural influences on body image and eating

disturbance. In C. G. Fairburn & K. D. Brownell (Eds.), *Eating disorders and obesity: A comprehensive handbook* (2nd ed., pp. 103-107). NY/ London, UK: The Guilford Press.

Szymanski, M. L., & Cash, T. F. (1995). Body-image disturbances and self-discrepancy theory: Expansion of the Body-image Ideals Questionnaire. *Journal of Social and Clinical Psychology, 14(2),* 134-146.

Thompson, J. K. (1990). *Body image disturbance: Assessment and treatment.* NY: Pergamon Press, Inc.

Thompson, J. K. (2004). The (mis)measurement of body image: Ten strategies to improve assessment for applied and research purposes. *Body Image, 1,* 7-14.

Veale, D., Gournay, K., Dryden, W., Boocock, A., Shah, F., Willson, R., et al. (1996). Body dysmorphic disorder: A cognitive behavioural model and pilot randomised control trial. *Behaviour Research and Therapy, 34(9),* 717-729.

Williamson, I., & Hartley, P. (1998). British research into the increased vulnerability of young gay men to eating disturbance and body dissatisfaction. *European Eating Disorders Review, 6,* 160-170.

World Health Organisation (2004). Body Mass Index (BMI). Retrieved June 8, 2004, from http://www.euro.who.int/nutrition/20030507_1

Appendixes

Appendix A

Guide for Authors: Body Image

Guide for Authors

Body Image is an international, peer-reviewed journal that publishes high-quality, scientific articles on body image and human physical appearance. Body Image is a multi-faceted concept that refers to persons' perceptions and attitudes about their own body, particularly but not exclusively its appearance. The journal invites contributions from a broad range of disciplines psychological science, other social and behavioral sciences, and medical and health sciences. The journal publishes original research articles, brief research reports, theoretical and review papers, and science-based practitioner reports of interest. Dissertation abstracts are also published online, and the journal gives an annual award for the best doctoral dissertation in this field.
Submission of an article implies that the work described has not been published previously (except in the form of an abstract or as part of a published lecture or academic thesis), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, without the written consent of the Publisher.

Submission

Authors can upload their article as a **LaTeX, Microsoft® (MS) Word®, WordPerfect®, PostScript or Adobe® Acrobat® PDF** document via the "Author Gateway" page of this journal (http://authors.elsevier.com/journal/bodyimage through the "submit online to this journal" link), where you will also find a detailed description on its use. The system generates an Adobe Acrobat PDF version of the article which is used for the reviewing process. It is crucial that all graphical and tabular elements be placed within the text, so that the file is suitable for reviewing. Authors, Reviewers and Editors send and receive all correspondence by e-mail and no paper correspondence is necessary.
Note: Electronically submitted manuscripts are converted into PDF for the review process but may need to be edited after acceptance to follow journal standards. For this an "editable" file format is necessary. See the section on "Electronic format requirements for accepted articles" and the further general instructions on how to prepare your article below.
Online submission is strongly preferred but authors can also submit via mail. Four (4) copies of the manuscript, plus the file on computer disk, including one set of high-quality original illustrations, suitable for direct reproduction, should be submitted to the Editor-in-Chief, Thomas F. Cash, Ph.D. Department of Psychology, Old Dominion University, Norfolk, VA 23529, USA Tel: +1 757 683 4439, Fax: +1 757 683 5087, Email: bodyimage@odu.edu:. (Copies of the illustrations are acceptable for the other sets of manuscripts, as long as the quality permits refereeing.)

Electronic format requirements for accepted articles

Wordprocessors - General points
We accept most wordprocessing formats, but Word, WordPerfect or LaTeX is preferred. Always keep a backup copy of the electronic file for reference and safety. Save your files using the default extension of the program used.

Wordprocessor documents
It is important that the file be saved in the native format of the wordprocessor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the wordprocessor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. Do not embed 'graphically designed' equations or tables, but prepare these using the wordprocessor's facility. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Author Gateway's Quickguide: http://authors.elsevier.com). Do not import the figures into the text file but, instead, indicate their approximate locations directly in the electronic text and on the manuscript. See also the section on Preparation of electronic illustrations.
To avoid unnecessary errors you are strongly advised to use the 'spellchecker' function of your wordprocessor. Although Elsevier can process most wordprocessor file formats, should your electronic file prove to be unusable, the article will be typeset from the hardcopy printout.

Brief Reports

These should not exceed 2,500 words (excluding abstract, references, and tables). Up to two one-page tables of figures are permitted, and the number of references should not exceed 25.

Presentation of manuscript

Please write your text in good English (American or British usage is accepted, but not a mixture of these).

Style. Manuscripts must adhere to the instructions on references, preparation of tables and figures, abstracts,

manuscripts format, etc. as described in the *Publication Manual of the American Psychological Association,* 5th ed., ISBN 1-55798-790-4, copies of which may be ordered from http://www.apa.org/books/4200061.html or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Manuscripts that do not conform to the style set forth in the *Manual* will be returned for revision. The title of the paper, the author's name and full postal address to which proofs should be sent and the name and address of the institute, hospital, etc., where the work was carried out should be indicated on the cover sheet of the paper. Please supply the corresponding author's telephone and fax numbers, and E-mail.

Computer Disks. Authors who choose to submit their manuscript by mail are encouraged to submit a 3.5" HD/DD computer disk to the editorial office. Please observe the following criteria:
1. Make sure that the disk and the hard copy match exactly (otherwise the diskette version will prevail). 2. Specify what software was used, including which release, e.g., WordPerfect 6.0a. 3. Specify what computer was used (IBM compatible PC, Apple Macintosh, etc.). 4. The article file should include all textual material (text, references, tables, figure captions, etc.) and separate illustration files, if available. 5. The file should follow the general instructions on style/arrangement and, in particular, the reference style of this journal as given in the Instructions to Contributors. 6. The file should be single-spaced and should use the wrap-around end-of-line feature, i.e., *returns at the end of paragraphs only.* Place two returns after every element such as title, headings, paragraphs, figure and table call-outs. 7. Keep a backup disk for reference and safety.

Tables and Figures. All tables and figures should be numbered separately using Arabic numerals, and grouped together at the end of the manuscript. Clearly visible notes within the text should indicate their approximate placement. Figures must be camera-ready; photocopies, blue ink, or pencil are not acceptable. Use black India ink, and type figure legends on a separate sheet. Write the article title and figure number lightly in pencil on the back of each.

Abstract. A concise and factual abstract is required (maximum length 150 words). The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone.

Keywords. Authors should include up to six keywords with their manuscript, placed on the same page beneath the abstract.

References. References in the text and reference list should follow the guidelines laid out in the *Publication Manual of the American Psychological Association,* 5th ed. (details above).
Examples:

Reference to a journal publication:
Feingold, A., & Mazzella, R. (1998). Gender differences in body image are increasing. *Psychological Science, 9,* 190-195.

Reference to an authored book:
Phillips, K. A. (1996). *The broken mirror: Understanding and treating body dysmorphic disorder*. New York: Oxford University Press.

Reference to an edited book:
Cash, T. F., & Pruzinsky, T. (Eds.). (2002). *Body image: A handbook of theory, research, and clinical practice*. New York: Guilford Press.

Reference to a chapter in an edited book:
Sarwer, D.B. (2001). Plastic surgery in children and adolescents. In J. K. Thompson & L. Smolak (Eds.), *Body image, eating disorders, and obesity in youth: Assessment prevention, and treatment* (pp. 341-366). Washington, DC: American Psychological Association.

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Submitting your artwork in an electronic format helps us to produce your work to the best possible standards, ensuring accuracy, clarity and a high level of detail.

General points

- Always supply high-quality printouts of your artwork, in case conversion of the electronic artwork is problematic.
- Make sure you use uniform lettering and sizing of your original artwork.
- Save text in illustrations as "graphics" or enclose the font.
- Only use the following fonts in your illustrations: Arial, Courier, Helvetica, Times, Symbol.

- Number the illustrations according to their sequence in the text.
- Use a logical naming convention for your artwork files, and supply a separate listing of the files and the software used.
- Provide all illustrations as separate files and as hardcopy printouts on separate sheets.
- Provide captions to illustrations separately.
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Files can be stored on 3? inch diskette, ZIP-disk or CD (either MS-DOS or Macintosh). This journal offers electronic submission services and graphic files can be uploaded via the Author Gateway page of this journal via http://authors.elsevier.com/journal/bodyimage.
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Formats
Regardless of the application used, when your electronic artwork is finalised, please "save as" or convert the images to one of the following formats (Note the resolution requirements for line drawings, halftones, and line/halftone combinations given below.):
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Please do not:

- Supply embedded graphics in your wordprocessor (spreadsheet, presentation) document;
- Supply files that are optimised for screen use (like GIF, BMP, PICT, WPG); the resolution is too low;
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Provide all illustrations as high-quality printouts, suitable for reproduction (which may include reduction) without retouching. Number illustrations consecutively in the order in which they are referred to in the text. They should accompany the manuscript, but should not be included within the text. Clearly mark all illustrations on the back (or - in case of line drawings - on the lower front side) with the figure number and the author's name and, in cases of ambiguity, the correct orientation.
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Proofs. *When your manuscript is received by the Publisher it is considered to be in its final form. Proofs are not to be regarded as 'drafts'.* One set of page proofs in PDF format will be sent by e-mail to the corresponding author, to be checked for typesetting/editing. No changes in, or additions to, the accepted (and subsequently edited) manuscript will be allowed at this stage. A form with queries from the copyeditor may accompany your proofs. Please answer all queries and make any corrections or additions required.

Elsevier will do everything possible to get your article corrected and published as quickly and accurately as possible. In order to do this we need your help. When you receive the (PDF) proof of your article for correction, it is important to ensure that all of your corrections are sent back to us in one communication. Subsequent corrections will not be possible, so please ensure your first sending is complete. Note that this does not mean you have any less time to make your corrections, just that only one set of corrections will be accepted.

Reprints. Reprints may be purchased at a reasonable price if ordered on the form which will accompany the proofs. Twenty-five (25) free reprints are provided. Orders for additional reprints must be received before printing in order to qualify for lower prepublication rates.

Appendix B

Interpretative Phenomenological Analysis: Epistemological Perspective

Epistemological Perspective

Interpretative Phenomenological Analysis (IPA) draws on phenomenology, in its concern with individual experience, and is also influenced by symbolic interactionism, in its emphasis on interpretation, and the social context in which meaning is created (e.g. Smith, 1996). Whilst IPA overlaps with social cognition approaches in assuming a link between participants' accounts and their underlying beliefs (Smith, Jarman, & Osborn, 1999), it is also explicit in its recognition that this link is not direct. The meanings of interview data are, therefore, dependent on an interpretative process, that will inevitably draw on the researcher's own perspective (e.g. Smith et al., 1999). As such, IPA does not consider interview data to constitute a factual account of an objective truth. However, in view of the link, assumed to exist between participants' accounts and their underlying cognition, nor does it suggest that the meanings based on such accounts are entirely divorced from the participants' internal reality. Thus, IPA has been described as adopting "something like a critical realist position" (Larkin, 2003, p. 3).

IPA was considered appropriate to the current study with respect to both its focus on experience, and emphasis on interpretation. These perspectives were consistent with the stated aims of the study; to develop understanding of the phenomenon of BD as it is experienced by men, whilst acknowledging the likelihood that existing theory may inform interpretation of this experience.

References

Larkin, M. (2003, June). *Interpretative phenomenological analysis.* Introductory workshop material provided at the 5th Annual IPA Conference, University of Plymouth, UK.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health, 11,* 261-271.

Smith, J. A., Jarman, M., & Osborn, M. (1999). Doing interpretative phenomenological analysis. In Murray, M., & Chamberlain, K. (Eds.), *Qualitative health psychology: Theories and methods* (pp. 218-240). London, UK: Sage.

Appendix C

Confirmation of Ethics Committee Approval

University of Southampton

School of Psychology

University of Southampton
Highfield Southampton
SO17 1BJ United Kingdom

Tel +44 (0)23 8059 3995
Fax +44 (0)23 8059 4597

27 August 2003

Gillian Adams
Department of Clinical Psychology
Highfield
Southampton SO17 1BJ

Dear Gillian,

Re: Body Dissatisfaction in adult males: An exploratory study

The above titled application - which was recently submitted to the School of Psychology Ethical Committee, has now been given approval.

Should you require any further information, please do not hesitate in contacting me on 023 8059 3995.

Yours sincerely,

KLucas

Kathryn Lucas
Ethical Secretary

Appendix D

Study Advertisement Posters

Male Body Image

Research study looking at experiences of Body Dissatisfaction in adult men:

If you are a male, aged between 18 and 35, I am interested in hearing your views

If you would like to take part, you will be asked to complete two short questionnaires. You may then be asked to take part in an individual interview, to discuss your views on this topic.

Interviews would last up to an hour and a half. Times and dates are flexible, and may be made at your convenience. You may choose whether you would rather talk to a male or female researcher.

To take part, please contact Gillian Adams at gca201@soton.ac.uk or alternatively, send your preferred contact details to:
Gillian Adams, Clinical Psychology, Shackleton Building 44, University of Southampton, SO17 1YN

University Study code: GA1

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gca201@soton.ac.uk
gca201@soton.ac.uk
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gca201@soton.ac.uk
gca201@soton.ac.uk

Male Body Image

Research study looking at experiences of Body Dissatisfaction in adult men:

If you are a male, aged between 18 and 35, I am interested in hearing your views

- **Earn ONE CREDIT by filling in TWO SHORT QUESTIONNAIRES**
- **Earn SEVEN MORE CREDITS if you are asked to take part in an interview**
- **Earn up to TWO MORE CREDITS if you are asked to take part in a brief follow-up**

Interviews would last up to an hour and a half. Times and dates are flexible, and may be made at your convenience. You may choose whether you would rather talk to a male or female researcher.

To take part, please contact Gillian Adams at gca201@soton.ac.uk or alternatively, send your preferred contact details to:
Gillian Adams, Clinical Psychology, Shackleton Building 44, University of Southampton, SO17 1YN

Study Code: GA1/ Poster agreed with School of Psychology Main Office

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gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk gca201@soton.ac.uk

Appendix E

Summary of Interview Skills Training Session

Interview Skills Training

Beginning the Interview

- Start by reminding the participant of who you are and what you are doing. An explanation of the study should be detailed enough that participants will be prepared for what is expected of them (Seidman, 1998), but should not give details of specific questions or subject areas; it is the participants' spontaneous, not prepared, thoughts we are interested in (Oppenheim 1992). Remind participants that it is their perspective we are interested in, and that we hope they will feel free to share whatever they feel to be relevant (i.e. "anything goes").

- Neutral conversation before the interview may help relax the respondent, and get the conversation going (Yardley, 2002).

- Oppenheim (1992) suggests that beginning the interview with a broad projective question such as "Now, first of all, would you like to tell me a little about yourself?" (p. 71) can be helpful in getting the interviewee used to the process of the interview, and also provides information about how the participant chooses to present himself.

General Interviewing Skills

Adapted from Hennessey (1997) and Yardley (2002)

- Attending Behaviour:
  - Make eye contact, but don't stare
  - Use body language, e.g. sit at right angles, or diagonally, look relaxed, nod head, smile
  - Tone of voice should be appropriate to what the interviewee is saying, as well as its emotional connotations.

- Use of Open Questions:
  - Open questions (e.g. How, why, what, tell me about...) draw out more information than closed, and are less likely to be responded to with a yes/no answer.

- Observing the interviewee:
  - The participant's verbal responses are clearly important, and will be recorded. However, it is also important to be alert to behaviour within the interview, for example hesitations, which may help to highlight what the interviewee is *not* directly saying (Oppenheim, 1992), and may help the interviewer to decide on

topics to pursue. It may be helpful for the interviewer to note down such observations, which will not be evident in the audio recording, immediately following the interview.

- Encouraging, prompting, and summarising:

  - Encouragers can be non-verbal, e.g. nodding, smiling, or just allowing long pauses- don't feel that you need to rush in with a new question, the participant may continue to speak.
  - Neutral, non-leading verbal prompts can include e.g. "uh huh", "tell me more about that".
  - Summarising what that participant has said can be useful to check your understanding, and may help the interviewee feel that they are really being listened to. This can range from simply restating what the participant has said, or the emotions that they have reported (e.g. "So you felt upset"), to paraphrasing what has been said, or summarising the themes from a larger section of the interview. This can also be useful as a cue to move on to a new topic.

- Don't interrupt the interviewee: you may have to make a mental note of interesting points to return to later.

- Take the participant seriously; value what they have to say (Seidman, 1998). Oppenheim (1992) stresses the importance of generating a non-judgmental atmosphere where the interviewee feels able to explore ideas that, for example, may seem irrational.

- AVOID a therapeutic relationship (Seidman, 1998). Be aware of the limitations of the interview relationship, and of the appropriate steps that should be taken, if, for example, the participant becomes distressed.

Use of the Interview Schedule

- Although the schedule contains specific questions, this is to act more as a 'hidden agenda' than a definite script (Oppenheim, 1992). The interviewer should "seek to direct the interview as unobtrusively as possible" (Oppenheim, 1992, p. 67) around these areas of interest, and will not always ask questions in the same order, or in exactly the same words.

- Issues may be raised by participants, which have not been anticipated by the interview schedule. It is important that these are acknowledged; we are seeking to understand the participant's experience, and the interview schedule is unlikely to be comprehensive. However, too much time away from the schedule may also result in a failure to generate relevant responses. Participants may be redirected; Oppenheim (1992) provides a useful example of such redirection:

"Shall we come back to this later, after I have finished my questions?" (p. 73).

- Questioning around each aspect of body dissatisfaction is to be iterative, such that prompting should occur around each aspect until no new information is forthcoming.

Practicalities and Safety

Parts adapted from Raphael (2003)

- Telephoning the participant before leaving for an interview, if possible, may be helpful to check that it is still convenient.

- Venue: for this study, rooms will be booked at the University wherever possible. Where this is not possible, the interviewer should take the following precautions: make appointments during daylight hours wherever possible, advise a third person as to the likely duration of their appointment, arrange to contact this person at an agreed time, and leave a mobile number on which they may be contacted. Details of their location, if confidential, should be left in a sealed envelope and destroyed by the interviewer on their return.

- Check that tape recorder is working, take spare tapes and batteries and a notebook and pens.

Points Relating Specifically to This Study

- Gender issues: be aware that interviews conducted by interviewers of the same gender may not be "automatically unproblematic" (Seidman, 1998, p. 86). It is important to be aware of assumptions that the interviewee may hold regarding shared perspectives (Seidman, 1998) based on gender (e.g. "You know what it's like…")- if you are not sure of a participant's meaning, ask them to be explicit.
- Steps to take if a participant becomes distressed during an interview: the participant should be given the opportunity to discuss their concerns, to take a break, or discontinue the interview. If necessary, participants should be directed towards appropriate forms of support, and given a written letter providing additional details regarding this.
- Try to end the interview with a discussion of positive aspects of the participant's body image. If the participant is unable to think of any, try to end instead with a brief discussion of a more neutral subject. Participants should not leave the interview in a state of uncontained distress.
- Participants should be given the opportunity to write down anything that they might wish to share, but not feel happy about disclosing verbally.

- At the end of the interview, participants should be provided with a debriefing sheet, and given the opportunity to ask any questions.

References

Hennessey, M. (1997). *Interviewing and counselling skills: Two day workshop.* Unpublished teaching materials. University of Southampton, UK.

Oppenheim, A.N. (1992). *Questionnaire Design, interviewing and attitude measurement.* (2nd ed.). London, UK: Pinter.

Raphael, H. (2003). *Interviewing and data analysis in qualitative research,* Unpublished teaching materials. Research and Development Support Unit, University of Southampton, UK.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences.* (2nd ed.). NY: Teachers College.

Yardley, L. (2002). *Qualitative research I & II.* Unpublished teaching materials. University of Southampton, UK.

Appendix F

Summary of Interpretative Phenomenological Analysis Training Session

Interpretative Phenomenological Analysis

Adapted from Larkin (2003)

What is IPA?

- Method of Qualitative data analysis
- Emphasis on subjective experience *(phenomenology)*
- Balance between emergent data-driven analysis, and *interpretation*. While some qualitative approaches (e.g. Grounded Theory) argue that all themes are to emerge from the data, uninfluenced by the researcher, IPA recognises the reality of theoretical preconception, and actively acknowledges this. In an initial two-stage process, information is drawn directly from the data (descriptive coding), and is then subject to a process of interpretation (interpretative coding), which may draw upon existing theoretical frameworks. Patterns between codes are then used to develop themes, within and across individual transcripts. Coding is not formulaic, but follows a basic process of movement from the descriptive to the interpretative, and from the specific to the more general. IPA is circular: the development of theoretical interpretations involves a move away from the original text. Such interpretations should, however, be supported by concrete examples taken verbatim from the text. Analysis is, therefore, transparent.
- Emphasis on constructionism: the "reality" of the interview data arises as a result of the interviewer/interviewee relationship. The stages of interview and analysis are inextricably linked. It is therefore important that researchers are transparent at *all* stages of the project regarding their observations and experiences. This reflexive account helps to place the interview data in the context within which it was "constructed". This is important for both the analysis and the credibility of the final account.

Interviewing and IPA

- Although different interviewers will undoubtedly vary in their dynamic with participants, it is important that a *degree* of comparability exists across interviewers. This should be achievable by broadly following the agreed schedule.

- Again, although the interview schedule may be modified to include emerging points of interest to a *degree*, it is important that the interviews are broadly comparable over time (i.e. not constantly evolving to ask different questions). Ideally, a fairly consistent schedule should be achieved after the first few interviews.

- Initial interviews should be transcribed and examined before further interviews take place. This can be useful in highlighting the types of errors to avoid in later interviews. If the quality of initial interviews is considered too poor, they may be treated as pilots and discarded from the final data set. It is not necessary to determine whether initial interviews will be included in the analysis prior to this examination.

A Reflexive Account

IPA recognises the joint contributions of both participant and researcher in constructing the "truth" of interview data. It is essential that researchers involved in each stage of the project actively reflect upon their own preconceptions and feelings, and the ways in which these may have contributed to the data. This is important at the stage of analysis, when the researcher constructs an interpretation of the data, but also during interview. Although good interview technique avoids the use of leading or closed questions, and thus aims to minimise the researcher's own bias, and the limits imposed on which aspects of their experience a participant is able to share, a reflexive account of ideas and feelings encountered during the interview may provide the analyst with a broader sense of the overall process taking place, and add to the interpretation. The reflexive account may be used informally as an indicator of interview quality, but may also be included in the write-up as a transparent acknowledgement of the joint construction of the results (Smith, 1995).

Such a reflexive diary could usefully include:

- Interviewer's feelings: e.g. if the interviewer felt uneasy during a certain part of the interview.
- Observations: e.g. the participant went very red while answering a particular question, or their body language (e.g. fidgety, nervous) was not in keeping with the happy story they were telling.

Smith (1995) provides a useful summary of criteria to consider in constructing such a reflective account.

Qualitative "Reliability"

IPA does not aim to achieve inter-analyst reliability. The nature of interpretative coding is such that two analysts may produce contrasting accounts. What is important is that each account is transparent, such that the plausibility of the decisions made in the coding process may be assessed (Smith, 2003).

The role of a reviewer is to examine the paper trail from interview through to completion of analysis (again, why it is so important to have reflexive accounts at both the interview and analysis stages) to determine whether the decisions made within coding have been systematic, plausible, and justified (Smith, 2003).

References

Larkin, M. (2003, June). *Interpretative phenomenological analysis.* Introductory workshop material provided at the 5th Annual IPA Conference, University of Plymouth, UK.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, & L. Van Langenhove (Eds.), *Rethinking Methods in Psychology* (pp. 9-26). London, UK: Sage.

Smith, J. A. (2003). Validity and qualitative psychology. In J. A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (pp. 232-235). London, UK: Sage.

Appendix G

Interview Schedule: Final Version

Interview Schedule

General Introduction:

e.g. As you know from the Information Sheet you've read, I'm trying to find out about men's experiences of body image, and body dissatisfaction, so I'll be asking you some questions that are related to this. Over the course of the study, I'll be talking to people who might have quite different ideas about this. I'm really interested in each of these perspectives, so I hope you'll feel able to share your thoughts with me about this subject, whatever they might be.

STATE CODE NUMBER OF PARTICIPANT BEFORE INTERVIEW, FOR THE BENEFIT OF THE TAPE. AVOID USING THE PARTICIPANT'S FULL NAME/ ANY OTHER IDENTIFYING DETAILS

Broad Opening Question:

- What do you understand by the term 'Body Image'?

Interview Schedule proper- Main themes, general questions and specific prompts (for use where needed):

1. The Ideal Male Body

- What do you think society in general sees as an 'ideal' male body?
- What makes you think that this is society's ideal?
- Does this differ from how you would describe an 'ideal' male body?
  (Prompt if necessary: How does this differ? Why do you think this is?)
- How/ why do you think this has developed as your ideal?
- What do you think potential partners (girlfriends/ boyfriends) see as the 'ideal' male body?
- What do you think your friends/ mates see as the ideal male body?

2. Concerns about own body

- How do you feel about your own body?/ the way you look?
- Is there anything you don't like about your own body?/ What do you like least about your own body?
  (Prompts: What specific part of your body is it that you don't like?/ What is it about this part of your body that you don't like?/ Thoughts?/ Feelings? These prompts may be repeated for each specific body area discussed, if more than one).
  FOLLOWING participant's spontaneous responses, ask specifically about weight and shape related concerns if these have not been discussed already

3. Antecedents to concerns

- What things trigger/ set off your dislike for this part of your body?

4. Consequences of concerns

- What is the result, for you, of not liking this part/ these parts of your body?/ the way you look?
  (Prompts: What do you do?/ Is there anything you would NOT do or avoid doing?/ What do you think?/ What do you feel?)

5. Body Satisfaction

- Tell me what you like most about your body

Ending the Interview:

- *Thank participant*
- *Ask participant if there is anything that they have not been happy to disclose verbally, but would be willing to write down.*
- *Provide debriefing sheet, and opportunity for questions.*

Appendix H

Participant Characteristics Questionnaire

Participant Characteristics Questionnaire (27/8/2003)

Due to the nature of the study, the following questions are concerned with very personal information about you. I would like to remind you that you are under no obligation to answer questions if you do not wish to. Any responses that you do give will be kept strictly confidential. Completed questionnaires will only be seen by researchers involved in the study. Thank you for reading this.

1. How old are you? .....

2. Do you engage in regular exercise (NOT part of normal routine such as walking to work)?

YES/ NO (Please circle)

If NO please go to Question 3

If YES:

a. In what activities do you engage?

.....

.....

.....

b. How many times a week do you engage in each activity?

.....

.....

c. For how long do you engage in each activity on each occasion?

.....

.....

3. Have you ever been diagnosed with an Eating Disorder?

YES/ NO (Please circle)

If NO please go to Question 4

If YES:

a. What type of Eating Disorder was it?

.....

b. When were you diagnosed?

.....

4. What is your sexual orientation? (Please indicate)

Heterosexual	.....
Homosexual	.....
Bisexual	.....
Decline to respond	.....

5. What ethnic group do you belong to? (Please indicate)

White	.....
Black	.....
Asian	.....
Other (please describe)	.....
Decline to respond	.....

Thank you for your help with this study.

Appendix I

Participant Information

In order to maintain anonymity, all names have been changed, and only limited detail has been provided regarding participants' occupation.

Derek was a 32 year old white, gay man with a BMI of 31.4. He worked full-time in an office, and cycled to and from work each day. He did not describe any other regular exercise. He had no previous diagnosis of eating disorder, and had a total score of 4 on the EAT-26.

Liam was a 21 year old, white bisexual man. He was employed in the armed forces and reported using the gym twice a week. Liam had a BMI of 25.4, had never been diagnosed with an eating disorder, and scored 12 on the EAT-26.

Paul was a 22 year old white man who worked with animals. He engaged in weight training exercise four times a week, and also practised boxing and basketball twice a week. He described himself as heterosexual, and had never been diagnosed with an eating disorder. Paul had a BMI of 25.2, and a total score of 7 on the EAT-26.

Steven was a 25 year old white, heterosexual man, who worked full-time in an office. He went jogging twice a week, and cycled five days a week. He had a BMI of 23.2, had never been diagnosed with an eating disorder, and had a total score of 1 on the EAT-26.

Oliver was a 24 year old student. He was white, and described himself as homosexual. Oliver attended the gym twice a week, and also swam once a week. He had a BMI of 20.9, had never been diagnosed with an eating disorder, but scored 33 on the EAT-26.

Tom was a 22 year old white, gay man. He was a student, and did not engage in any exercise. Tom had a BMI of 34.1, had never been diagnosed with an eating disorder, and scored 3 on the EAT-26.

Ben was a 22 year old student. He described himself as white, and homosexual. He did not engage in any exercise, and had a BMI of 19.9. Ben scored 1 on the EAT-26.

Nick was a 24 year old student. He was white, and described himself as heterosexual. He engaged in cycling five or six times each week, and had a BMI of 20.7. Nick had no history of eating disorder diagnosis, and scored 3 on the EAT-26.

Michael was a 29 year old bisexual man. He was a student, and engaged in rowing and weight training three to four times a week. Michael was white, had a BMI of 18.4, and a total score of 1 on the EAT-26.

Mark was an 18 year old student. He was white, and described himself as heterosexual. Mark reported doing press-ups every morning, going to the

gym once a week, and cycling for a couple of hours each week. He had a BMI of 20.8, had never had an eating disorder, and scored 4 on the EAT-26.

Lewis was a 24 year old student. He described himself as white/ middle eastern, and was heterosexual. He engaged in cardiovascular exercise at the gym two to three times each week, and had never had an eating disorder. Lewis had a BMI of 27.7 and a score of 5 on the EAT-26.

Anthony was a 19 year old, white, heterosexual student with a BMI of 24.2. He engaged in swimming, football, and cycling on a weekly, twice weekly and daily basis, respectively, and had never been diagnosed with an eating disorder. Anthony's total EAT-26 score was 4.

Gareth was a 25 year old, white, heterosexual student. He reported walking for up to an hour each day, and played squash once a week. He had a BMI of 31.3, had never been diagnosed with an eating disorder, and scored 4 on the EAT-26.

Dominic was a 19 year old white, gay student. He engaged in both weight-training and cardiovascular activities at the gym three times a week, and had never had an eating disorder. Dominic had a BMI of 26.9, and scored 12 on the EAT-26.

Appendix J

Participant Information Sheet

University of Southampton

Department of Psychology

Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ
United Kingdom

Telephone +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588
Email

Participant Information Sheet (Dated 27/8/2003)

Body Dissatisfaction in adult males: An exploratory study

You are being asked to take part in a research study. Before you decide, it is important for you to understand why the research is being done, and what it will involve. Please take time to read the following information carefully, and discuss it with others if you wish. Please ask me if there is anything that is not clear, or if you would like more information. Thank you for reading this.

What is the purpose of the study?

We are conducting a research study that looks at experiences of body dissatisfaction in men aged 18 to 35. It is hoped that this research will lead to better understanding of the problems and issues that men may face, related to their body image.

Why have I been asked to take part?

In order to gain a cross-section of experiences, a wide variety of men have been asked to take part. In this way, we hope to gather information from men whose experiences may be quite different.

Do I have to take part?

It is up to you to decide whether or not you wish to take part. Your decision will not affect any services you receive.

What will happen if I take part?

If you decide to take part, you will be asked to complete two short questionnaires, from which a number of health related scores will be generated. You will also be asked to provide details of how you may be contacted by the researcher. This is because you may be asked to take part in an individual interview with a researcher, to talk about your experience of

body image. The researcher will contact you to arrange a time and date at your convenience. The interviews will be tape-recorded.

Will my taking part in the study be kept confidential?

All information, which is collected during the course of the research, will be kept strictly confidential. If you choose to take part, the researcher will have access to your name and contact details. These will not be disclosed to anyone other than the interviewing researchers, unless you are participating in order to earn course credit. In this instance, your name will need to be shared with the relevant department, in order for you to be allocated your credits. However, no information involving your responses will be shared. Your name will be given only to inform those concerned that you took part in the study. All written information that you complete, or that is completed about you, as part of the study, will be kept anonymous. Your written questionnaire responses will be seen only by researchers involved in the study. Audio-tape recordings of interviews will be stored securely, and only the researchers involved in the study will have access to these. Following the required period of five years, the recordings will be destroyed. Any comments that you make, which are used in the report of the study will be anonymous, with any identifying information removed.

What will happen to the results of the study

A report of the results will be written and submitted to the University of Southampton, and may also be written up for publication. This report will summarise the findings, but will not identify any individual. A briefer summary of the results will be made available to you on request.

Who is organising and funding the research?

The study is being conducted by myself, Gillian Adams, Trainee Clinical Psychologist, Dr. Romola Bucks, Senior Lecturer, Department of Psychology, University of Southampton, and Dr. Hannah Turner, Clinical Psychologist. We are being assisted in this study by three additional psychologist interviewers; Philip Moore, Alex Fowke and Matt Symes.

Who has reviewed the study?

The Department of Psychology Research Ethics Committee, University of Southampton has reviewed the study.

If you have any questions about your rights as a participant in this research or you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Tel: 023 8059 3995.

Contact for further information

If you have any questions, or you wish to request a summary please do not hesitate to contact me, Gillian Adams, or Dr. Romola Bucks at:
Department of Clinical Psychology, University of Southampton, SO17 1BJ
Tel: 023 8059 5321, email: gca201@soton.ac.uk

Appendix K

Consent Form

University of Southampton

Department of Psychology

Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ
United Kingdom

Telephone +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588
Email

CONSENT FORM

Body Dissatisfaction in adult males: An exploratory study

Gillian Adams
Department of Clinical Psychology
University of Southampton
SO17 1BJ
Tel: 023 8059 5321

Please initial box

1. I confirm that I have read and understood the information sheet (dated 27/8/2003) for the above study. ☐

2. I understand that my participation is voluntary and that I am free to with draw at any time without any of the services that I receive, or my legal rights being affected. ☐

3. I have been given the opportunity to ask questions, and these have been answered satisfactorily. ☐

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

Name of participant	Date	Signature
Name of person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 for participant; 1 for researcher

Appendix L

Participant Debriefing Sheet

University of Southampton

School of Psychology
Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ United Kingdom

Tel +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588
Email

Body Dissatisfaction in Adult Males: An Exploratory Study

Theoretical Background

Previous research has indicated that the nature of body dissatisfaction may be different in men and women. However, although high levels of body dissatisfaction may place any individual at risk for a range of psychological disorders, much of the existing research has focused on female samples. Questionnaires designed to measure different aspects of body image are therefore often only applicable to women, or may not be representative of the full range of male concerns. The aims of this study were to conduct an exploratory investigation of body dissatisfaction in a range of adult males in order to identify common themes, and to use these themes as a basis for the development of preliminary items for a questionnaire measure. The following references provide more information about this topic:

Andersen A.E. (2002). Eating Disorders in Males. In C.G. Fairburn & K.D. Brownell (Eds.), *Eating Disorders and Obesity: A Comprehensive Handbook* (2nd ed., pp. 188-191). New York/ London: The Guilford Press.

Drewnowski, A., & Yee, D.K. (1987). Men and Body Image: Are Males Satisfied with their Body Weight? *Psychosomatic Medicine, 49,* 626-634.

Both references are available in the Hartley Library, at the University of Southampton.

Methodology

Participants completed questionnaires asking about a variety of personal characteristics. This was to help ensure that a group of men with varying characteristics would be invited to take part in the study. Participants were interviewed, using a semi-structured protocol, in order to prompt discussion regarding different elements of body image.

Results

Recorded interviews will be transcribed and made anonymous such that all identifying information relating to any participant is removed. Transcripts will be analysed qualitatively, using Interpretative Phenomenological Analysis, in order to identify common themes. A second Psychologist will review the analysis to establish agreement with the themes produced, but will not be privy to any identifying information about the participants. Some participants

will also be contacted again, and invited to take part in a second phase of the study, where they will be asked to comment on their agreement with the themes. Full information will be provided regarding this, and those participants invited to take part will be under no obligation to do so. Questionnaire items will then be produced to reflect the content of these themes.

A report of the results will be written up and submitted to the University of Southampton, and may also be submitted for publication. This report will summarise the findings, but will not identify any individual. A briefer summary of the results will be made available to you on request.
If you have any questions, or you wish to request a summary, please do not hesitate to contact me, Gillian Adams, or Dr Romola Bucks at: Department of Clinical Psychology, University of Southampton, SO17 1BJ. Tel: 023 8059 5321, email: gca201@soton.ac.uk

If you have any questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Tel: 023 8059 3995.

Appendix M

Follow-up Letter

University of Southampton

Department of Psychology

Doctoral Programme in Clinical Psychology

University of Southampton
Highfield
Southampton
SO17 1BJ
United Kingdom

Telephone +44 (0)23 8059 5321
Fax +44 (0)23 8059 2588
Email

Email: romola.bucks@soton.ac.uk

15th September, 2003

To participants in research into body dissatisfaction in males,

Thank you very much for taking part in this research study, which is being carried out by a Trainee Clinical Psychologist within the School research team. This letter is intended for anyone who may have found the interviews in which they took part distressing.

Of course, our feelings about our bodies can change from day to day. However, for some people, their thoughts or feelings may trouble them for some time. If this applies to you, we would like to point out that there are several sources of advice which are readily available and which may prove helpful. These include your General Practitioner, and if you are a member of the University, your tutor (where appropriate) and the University Counselling Service (8 University Crescent. Contact Joy Hayles on 023 8059 3719 to make an appointment).

If you would like additional information you can contact me, Dr. Romola Bucks, Senior Lecturer, School of Psychology (extension 2633).

Yours faithfully,

R Romola S. Bucks

Dr Romola Bucks, Phd C.Clin.Psychol. AFBPsS
Senior Lecturer in Clinical Psychology

Appendix N

Summary of Issues from Reflective Accounts

Salient points, from the reflective accounts of each interviewer are summarised below. These have been drawn together to highlight any significant issues as a whole, rather than on an individual interview basis.

Interviewer 1

In becoming acquainted with a participant prior to interview, the interviewer noted a mutual interest in sport and fitness, commenting that this may have contributed, to some degree, to a focus on these issues in the subsequent interview. The impact of such shared knowledge was evident in the use of slang abbreviations for technical terms related to weight training behaviour, such as particular muscle groups. However, the interviewer did not feel that there had been an adverse effect on the interview, noting that the participant appeared relaxed throughout.

Interviewer 2

The interviewer acknowledged feelings of hesitance on two occasions, related to having made some acquaintance with, or recognising a participant from, another setting. However, in reflecting on any possible influence on the participant, the interviewer in each case noted that the participant had appeared frank and open in his responses. The interviewer noted that the degree of rapport established with different participants varied, with some interviews being conducted in a more friendly, conversational manner, and

others seeming more formal. In each case, this appeared to be consistent with how the participants chose to engage in the interview process.

With regard to disclosure and discussion of body image concerns by participants, the interviewer made a number of reflections. In one case, the interviewer recognised having held assumptions that a participant was likely to be concerned about one aspect of his appearance, and acknowledged a possible influence on the focus of discussion, on the basis of this. This was considered in the analysis of the transcript, and any responses thought to arise from leading questions discounted. The interviewer also commented that a participant's persistent denial of concern regarding the issues he had raised might have indicated a greater level of concern than he was able or, perhaps, willing to make explicit. This sense was in keeping with the theme of denial, which emerged during subsequent analysis. Similarly, the interviewer noted that another participant had shared very little in the way of body image concerns. On reflection, the interviewer hypothesised that the participant had, perhaps, avoided discussion of any concerns, by denying their existence. Finally, the interviewer mentioned that one participant had directly fed-back a belief that men in general might find it difficult to "open-up" about their concerns in a non-therapeutic context.

Interviewer 3

Again, the interviewer noted that the tone of the interaction (i.e. conversational versus formal) varied across different interviews. Whilst in one case the interviewer and interviewee had made some prior acquaintance, it was noted that the participant had appeared relaxed, and had provided very frank information. The interviewer made some reflections about the respective roles of interviewer and interviewee in the interaction. For example, on one occasion, the respondent sought advice, following the interview, regarding his concerns, and may have seen the interviewer to some extent in a counselling role. In this instance, information regarding appropriate sources of support was reviewed with the participant. On no occasion did the interviewer note that a participant had appeared uncomfortable throughout an interview and no participant reported distress following the interview. Indeed, one participant fed-back that the interview, particularly discussion around feelings of distress, had been a positive experience.

In line with the subsequently emerging themes, one participant again fed-back a belief that men in general may not find it easy to talk about themselves. Finally, and again in keeping with the themes, on one occasion, the interviewer was struck by inconsistency between a participant's dismissal of concern, and their description of behaviours aimed at addressing these concerns.

Appendix O

Example Master List from One Transcript

Verbatim excerpts illustrating each theme/ sub-theme are shown in italics, with their line number.

NORMATIVE IDEALS

Physical description	*(quite tall, quite lean but quite toned 17)* *(quite tanned … normal distribution of hair 20)*
Shared vs individual/ Global vs specific	*(probably held by a lot of people 144)* *(veer off …depending on what their particular interests 145)* *(but the basic thing remains the same 31)* *(perception of thinness is, is, is much lower 660)*
Evolutionary origin	*(confers a, a perceived evolutionary advantage 99)*
Evidence	*(media portrayal, uh, what girls would say 37)* *(clothing adverts and models in magazines 46)*

SELF-PERCEPTION: Deviation from/ conformity to normative ideal

Physical descriptions	*(always thought I was small 176)* *(always quite, quite thin 181)* *(arms could be a bit more muscly 193)* *(rather my hairline was a bit further forward 229)* *(wouldn't mind looking a bit older 230)* *(almost the exact opposite of the ideal body image 324)* *(like the look of my legs…they're quite muscly 701)*

INFLUENCES ON SELF-PERCEPTION

Personal factors

• Experiences	*(it's going to be based on your own experiences 12)*
• Age	*(you're a bit younger and you're a bit more insecure 203)*

Interpersonal factors

- Others' comments *(someone said it to me last night 286)*
  (when my friends say it 381)
  (people saying something 499)
  (my mum...and my sister said it to me 285)
  (people have said that anyway 704)
  (my girlfriend's said that to me 711)

- Beliefs about Potential partners' views *(she'd probably like someone who's bigger 118)*
  (you think... girls really care about that 205)
  (more likely to pull... if you're a bit bigger 206)

MANAGING SELF-PERCEPTION

Concern/ Change

- Moving body towards ideal *(I would go to the gym 185)*
  (to try and conform 214)

Denial/ Acceptance

- Moving ideal towards body *(cycle magazines ... pros all look like me 395)*
  (biggish legs and thin arms... that's what you're aspiring to 399)

- Unable to change *(genetically going to always be relatively slim 331)*
  (things that you can't actually do that much about 335)
  (genetically programmed to look the way they do 338)

- Association/ attribution of of body shape to chosen sport *(if you're into a particular sport it gives you a lot of security 188)*
  (the way I look... is compatible with the sport I'm in 190)
  (I'm quite thin ... that's 'cause I ride my bike 269)
  (just something that happens if you do a lot of exercise 319)
  (the thing I want to do is be quick on a bike 330)

(it's just what you expect 388)
(a result of what I'm into 497)
(that's because I cycle a lot 574)

- Denial/ dismissal of concern or interest

(it's not that critical 126)
(I've never really spoken to them about this 138)
(I've never really discussed it 148)
(but then I, everybody, I mean I'm quite happy 194)
(I wasn't that bothered 217)
(I'm not that bothered 237)
(it isn't really high on my list of priorities 259)
(really doesn't bother me 579)

- Derogation of others

(being able to lift a bench press... either here nor there 106)
(look like idiots, guys who go down the gym 339)

Conflict: concern and denial about body image

(make my shoulders look broader ...I'm quite happy 239)
(perhaps I should do less training... but actually I don't really mind 275)
(maybe I am, um, but I don't really (have) concerns 288)
(not ever going to be... really wish I could 440)
("oh God, maybe I am"... but then that doesn't bother me 508)
(from a health point of view rather than from a body image point of view 293)
("that's quite bad" but... it's from a health perception 514)
(I guess, I mean sometimes.../ well, no 526)

MEANING OF APPEARANCE

Negative

(obesity's different ... overeat excessively and be very fat 345)
(if you're excessively fat... shows a lack of...self-control 720)

ACCEPTABILITY OF BODY IMAGE CONCERNS

A female issue

(I've never really spoken to them about this 138)
(It's not a…topic of conversation 165)
(mothers and grandmothers, and they say things like that 377)
(female relations tend to want to… feed you up 554)

Appearance vs function

- Negative connotations of appearance focus/ minimising own appearance focus

  (but again that's, my girlfriend's said that 711)
  (wouldn't say I've got a necessarily fantastically attractive face 708)
  (guys who look like they've been working out too much 77)

- Function not attractiveness

  (because… it says about what he's done 72)
  (a good athlete … therefore I can admire him 104)
  (always better at running and things 181)
  (goes hand in hand with … them being like best 413)
  (not because you find them attractive as such 459)
  (they're very efficient 482)
  (that's why I'd be worried…not because of what I look like 524)

Appendix P

Detail of Specific Participant Contributions to Themes

Table 1 *Participant contributions to sub-themes in the Societal Domain*

Theme	Sub-theme	Participant													
		A	B	C	D	E	F	G	H	I	J	K	L	M	N
Societal norms	Shared versus diverse	*	*	*	*	*	*	*	*	*	*	*		*	*
	Impact of nature and nurture	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Unacceptability of body image concern	Negative connotations of BD	*	*	*	*			*	*	*	*		*		*
	Variation across groups			*			*	*	*		*	*		*	
	Change over time/ gender roles	*		*					*	*	*		*	*	
Pressure to be perfect	Pressure to conform/ social acceptance	*		*				*	*				*		
	Connotations of not meeting ideals	*			*			*			*		*		*

*Note. * Participant contribution to sub-theme. A = Derek; B = Michael; C = Mark; D = Lewis; E = Steven; F = Oliver; G = Tom; H = Ben; I = Dominic; J = Paul; K = Liam; L = Anthony; M = Gareth; N = Nick.*

Table 2 *Participant contributions to sub-themes in the Interpersonal Domain*

Theme	Sub-theme	Participant													
		A	B	C	D	E	F	G	H	I	J	K	L	M	N
Body image as an Interpersonal construct	Interpersonal definition	*	*		*	*	*	*	*		*	*			*
	Importance of appearance to others	*	*	*	*	*	*	*	*	*	*		*	*	
Communicative function of appearance	Lifestyle/ attributes	*	*		*		*	*						*	*
	Masculinity/ strength/ viability	*	*			*		*	*	*	*	*	*		
Interpersonal influences on BD	Feedback	*	*	*	*	*	*	*				*	*	*	*
	Being seen	*				*	*	*	*						
	Sexual affirmation/ rejection	*			*	*		*		*	*	*	*		*
	Comparison	*		*	*		*	*	*	*	*		*	*	*

*Note. * Participant contribution to sub-theme. A = Derek; B = Michael; C = Mark; D = Lewis; E = Steven; F = Oliver; G = Tom; H = Ben; I = Dominic; J = Paul; K = Liam; L = Anthony; M = Gareth; N = Nick.*

Table 3 *Participant contributions to sub-themes in the Intrapersonal Domain*

Theme	Sub-theme	Participant													
		A	B	C	D	E	F	G	H	I	J	K	L	M	N
Importance of body image to the self	Source of self-esteem/ achievement	*		*	*				*	*					
The personal experience of BD	Emotional	*	*	*	*	*	*	*		*	*		*	*	
	Cognitive			*	*		*	*	*	*	*	*	*		*
	Somatic				*										
	Discrepancy		*	*				*		*				*	
Intrapersonal influences on BD	Seeing self	*	*		*	*	*			*	*	*	*		
	Cognitive distortion		*	*	*	*	*			*	*		*		
	Mood				*					*	*	*	*		
	Events highlighting/ reducing discrepancy	*		*	*	*	*	*	*	*		*	*		*

Management of BD- reducing discrepancy	Body change rules/ formulae	*	*	*	*	*	*		*	*	*	*	*	*	*		
	Disguise/ avoid being seen	*	*		*		*	*	*	*							
	Emphasise non-discrepant features	*						*	*								
	Reject/ derogate societal ideals	*						*			*					*	
	Affiliation with alternative ideals	*		*	*			*	*				*	*	*		
Management of BD- tolerating discrepancy	Comparison with others	*	*	*	*			*	*		*		*			*	
	Attributional style	*	*	*	*	*	*	*	*		*	*	*	*	*		
	Adjustment	*						*	*		*		*			*	
	Emotional coping			*	*	*	*	*		*	*		*	*			
Control	Inability to control	*	*		*	*	*		*		*	*	*	*	*		
	Ability to control	*			*		*	*	*	*	*	*		*			

*Note. * Participant contribution to sub-theme. A = Derek; B = Michael; C = Mark; D = Lewis; E = Steven; F = Oliver; G = Tom; H = Ben; I = Dominic; J = Paul; K = Liam; L = Anthony; M = Gareth; N = Nick.*

Table 4 *Participant contributions to themes and sub-themes in the Social Presentation Domain*

Theme	Sub-theme	Participant													
		A	B	C	D	E	F	G	H	I	J	K	L	M	N
Aim to be average						*							*		
Concern with function, not appearance		*	*	*	*	*			*		*		*	*	*
Denial and minimisation	Denial of interest/ concern	*	*	*	*	*		*	*	*	*	*	*	*	*
	Incongruence/ difficulty in emotional expression	*	*	*	*	*	*	*		*	*		*	*	
	Minimisation of positive traits	*	*	*		*	*	*	*				*	*	*
	Denial of extreme behaviour	*		*	*	*		*	*	*	*	*	*	*	

*Note. * Participant contribution to sub-theme. A = Derek; B = Michael; C = Mark; D = Lewis; E = Steven; F = Oliver; G = Tom; H = Ben; I = Dominic; J = Paul; K = Liam; L = Anthony; M = Gareth; N = Nick.*