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**Men's experiences of muscle dysmorphia in the UK: an
interpretive phenomenological analysis**

**A thesis submitted to the University of Huddersfield in
partial fulfilment of the requirements for Masters by
Research**

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ABSTRACT

The increasing pressure on men to achieve a muscular body has led men to pursue an unrealistic muscular body whilst experiencing body dissatisfaction and a distorted body image. Despite this, there is limited data on men's experiences of body image disturbance. Muscle Dysmorphia (MD), a sub-type of Body Dysmorphic Disorder (BDD), is a form of body image disturbance characterized by a disruptive and excessive preoccupation with muscularity. Previous research has utilized quantitative measures with samples of bodybuilders and undergraduates to investigate MD. The present study utilized Biographical Narrative Interview Method (BNIM) and Interpretative Phenomenological Approach (IPA) to explore the lived experiences of men who have experienced and recovered from MD. Three participants who self-identified to have experienced and recovered from MD were recruited from Facebook support groups. The analysis of the participants' narratives revealed three superordinate themes of 'the struggling self', 'the desire for muscularity' and 'road to recovery'. 'The struggling self' theme reflected men's struggle with their self-esteem and masculine identity as a result of childhood experiences. 'The desire for muscularity' reflected men's distorted body image and the pursuit of a muscular body as a coping strategy with psychological struggles. The theme 'road to recovery' represented men's journey from experiencing a low point in their lives to acquiring new perspectives towards their body image during therapy. The results are presented in relation to the wider literature. Future implications for practice and research are discussed.

INTRODUCTION

This chapter begins with a literature review. Within the literature review, I will provide background knowledge about body image disturbances and highlight the lack of research on men's gender-specific experiences of body image disturbance. I will then present a brief description of Body dysmorphic disorder to provide a context for its variant, muscle dysmorphia. Furthermore, I will outline existing theories, conceptual models, and social influences to consider how they explain the development of MD. Lastly, I will highlight the previous research limitation and the present study's contribution to knowledge about men's experience of MD.

Literature review

Body image

Body image refers to individuals' perceptions of their bodies and physical appearance (Hargreaves & Tiggemann, 2006). Cash (2012) defined body image as an individual's feelings and attitudes towards their body. Several studies have found that body image is a complex phenomenon that can involve cognitive, perceptual, mood and behavioural disturbances (Thompson, 1990; McKay-Parks & Read, 1997; Banfield & McCabe, 2002). Cash and Pruzinsky (2002) Suggested that body image consists of two essential dimensions: body image investment and evaluation. Body image investment refers to the degree of cognitive importance one feels towards their physical appearance, whereas body image evaluation refers to the degree of satisfaction one feels with their physical appearance. Earlier research on body image comparison between men and women have found that generally, women experienced higher levels of body image investment (Brown et al., 1990; Cash et al., 2004) whilst experiencing lower levels of body image satisfaction (Feingold &

Mazzella, 1998; Field et al., 1997). Thus, researchers prioritised understanding women's body image disturbances (see Hargreaves & Tiggemann, 2006).

Subsequently, Research on women's experiences of body image found several contributions such as biological (body mass index), psychological (low self-esteem), sociocultural (media and peer pressure) that influenced women's dissatisfaction with their physical appearance (Grogan, 2016). Although research on men's body image disturbances was scant, some researchers proposed that men's experience of body image disturbances mirrors women's experiences, though less in intensity and prevalence (see Smolak et al., 2001). However, Hargreaves and Tiggemann (2006) posited that the previous assumptions had overlooked men's gender-specific experiences of body image. For example, compared with women who feel dissatisfied about their body shape and weight, men are more concerned about their muscularity (Garner, 1997). Furthermore, men are more likely to minimise their experiences of body image disturbance due to the stigma that appearance concerns are feminine and unmasculine (Adams et al., 2005). Stanford and McCabe (2002) suggested that this difference in body image dissatisfaction between men and women results from different social expectations, in which women are expected to be thin and elegant, and men are expected to be muscular. This suggestion is also consistent with the socio-cultural model of body dissatisfaction, which posits that body dissatisfaction results from aspiring to attain unrealistic social beauty standards (Heinberg, 1996).

Research on the development of body image disturbances has found that a key driver of unrealistic body standards is the mass media (see Hargreaves & Tiggemann, 2006). This finding prompted researchers to investigate the role of media in body image disturbances (see Hargreaves & Tiggemann, 2006).

Subsequently, researchers found that the mass media such as television and magazine exposed the viewers to the images of thin women (see Ahmadi et al., 2018) and increasingly muscular men (see pope et al., 2018). For example, Law and Labre's (2002) study of men's portraits in magazines from 1967 to 1997 found that men's bodies were presented 'dramatically' more muscular over time.

Despite earlier findings on lack of data (e.g., Hargreaves and Tiggemann, 2006) men's experiences of body image disturbances continue to be a limited subject (Pope et al., 2018). Thus, men are less likely to seek help and more likely to be underdiagnosed when they seek treatment for body image disturbances due to a lack of gender-specific understanding of their experiences (Burlew & Shurts, 2013). Furthermore, due to the lack of prevention and intervention strategies for male-related body image disturbances, men have become so preoccupied with their bodies that it has become somewhat normative (Bégin et al., 2019). Moreover, cross-sectional surveys carried out over a decade has found that men are increasingly becoming dissatisfied with their bodies (Quittkat et al., 2019). In fact, body-image related eating disorders in men have increased at a higher rate than in women (Mitchison, Slewa-Younan & Mond, 2014). Nevertheless, body image disturbance is not a diagnostic term, but rather a general term used to refer to a wide range of issues related to the perception of physical appearance (Mizes et al., 2004).

Body dysmorphic disorder (BDD)

Body Dysmorphic Disorder (BDD) is diagnosed when individuals experience significant distress or functional impairment due to being preoccupied with their appearance (Blashill et al., 2020). This preoccupation can result from an imagined or a slight defect in one's appearance (Burlew & Shurts 2013). The American Psychiatric Association (2013) defines BDD as an excessive preoccupation of an

individual with a perceived or a slight flaw in their appearance. Individuals who experience BDD often engage in repetitive mirror checking, social comparison and persistent reassurance seeking (Blashill et al., 2020). Furthermore, BDD is associated with psychological disorders such as anxiety, depression and substance misuse (Angelakis et al., 2016). Moreover, BDD has the highest reported suicide thoughts and attempts across psychological disorders (Angelakis et al., 2016).

Such extreme health consequences of BDD highlight the importance of understanding BDD and its sub-types to improve prevention and intervention strategies. A subtype of BDD is a condition termed Muscle Dysmorphia (MD), which is primarily experienced by men (Blashill et al., 2020).

Muscle Dysmorphia (MD)

MD is categorised in the diagnostic and statistical manual of mental health disorders, fifth edition (DSM-5) as a variant of BDD (Blashill et al., 2020). However, unlike BDD, which refers to preoccupation with specific body parts (e.g., hair, hands or face), MD is characterized as an excessive preoccupation with muscularity (Pope et al., 2005). Individuals with MD perceive their bodies as small and insufficiently muscular though they may often be more muscular than average (Tod et al., 2016).

Pope et al. (2005) found that 22% of men diagnosed with BDD also met the diagnostic criteria for MD. However, In comparing men with BDD to men with MD, Pope et al. (2005) found that although both groups of men displayed the same severity in behaviours and body image distortion, men with MD experienced more severe psychological distress. Furthermore, men with MD reported higher suicide attempts, drug abuse, and anabolic steroid use than men in the BDD group. Pope et al. (2005) explained these finding by noting that men with MD experienced dysfunctional behaviours such as repetitive mirror checking and reassurance

seeking inherent in BDD alongside other dysfunctional behaviours unique to MD such as strict dieting and excessive weight training. Relatedly, Blashill et al. (2020) suggested that MD is more psychologically challenging for men as the perception of insufficient muscularity is more closely related to men's masculine identity than the perception of flaws in other parts of the appearance (e.g., face and hair).

Additionally, research has found that men with MD are found to be at a higher risk of mood and anxiety disorders (Cafri et al., 2008), depression, neuroticism, and perfectionism (Mitchell et al., 2017), obsessive-compulsive disorder symptoms (Rubio-Aparicio et al., 2020), lower self-esteem and self-perception (Chaney, 2008; Mitchell et al., 2017) and increased feelings of isolation (Chaney, 2008).

Individuals with MD often experience distress about how others view their bodies (Grieve, 2007). Thus, they engage in ritualistic behaviours such as strict dieting, extreme exercising and risky behaviours such as steroid abuse to increase muscularity (Grieve, 2007), whilst experiencing reduced social and occupational functioning (Nieuwoudt et al., 2012). Therefore, MD is diagnosed when an individual experiences a significant social or occupational disruption due to an excessive preoccupation with muscularity (Blashill et al., 2020).

Although the diagnostic and statistical manual of mental health disorders, fifth edition (DSM-5) includes MD as a variant of BDD, the debate regarding the clinical categorisation of MD is still ongoing amongst researchers who are yet to reach a consensus on whether MD is a sub-type of BDD, obsessive-compulsive disorder (OCD) or a form of eating disorder (see: Nieuwoudt et al., 2015). As mentioned earlier, MD was initially referred to as the reverse anorexia by Pope et al (1993) due to behaviours related to body weight, however, it has since been categorised as part of the BDD spectrum due to the manifestation of body image preoccupation and

eating disorders inherent in MD (McFarland & Karninski, 2008). It is worth mentioning that MD has been closely related to OCD for displaying behaviours that resemble ritualistic activities such as repetitive mirror checking (Phillips, 1998). Saying this, Foster et al. (2001) proposed a different categorisation for MD and suggested that MD could be classified as part of the addiction cycle due to extreme dieting and drug use to maintain a specific appearance. However, others have rejected the categorisation of MD as an addiction due to a lack of sufficient evidence (Nieuwoudt, 2015; Grant, 2014). Nevertheless, some researchers have doubted the validity of MD as a clinical disorder (see: Vandereycken, 2011). Sandgren and Lavalley (2018) suggested that the reason for the lack of consensus on MD's categorisation amongst researchers is due to the samples consisting of undergraduate men with self-report measures. Blashill et al. (2020) argued that reliance on such samples and measures makes it difficult to generalize the findings to clinical samples and the larger population.

Despite the debate around MD's categorisation, MD has most consistently been compared to Anorexia Nervosa (AN) due to their cognitive contrasts and behavioural similarities (see Murray et al., 2012). While MD is primarily experienced by men who perceive themselves to be thinner than they are, AN is primarily experienced by women who perceive themselves as fat or bulky despite being abnormally thin (Lee, 1994). Thus, Griffiths et al. (2014) suggested that if anorexia is viewed as a female issue because more women experience anorexia, MD can be viewed as a typical male issue. This contrast in perceptions between MD and AN also explains why MD was initially termed the reverse anorexia by Pope et al. (1993).

Although MD and AN share several similar characteristics such as extreme exercise patterns, rigid diet plans, reduced social and occupational functioning,

substance use and repetitive mirror checking (Murray et al., 2012), the main similarity between MD and AN is that the individual's self-opinion is strongly related to their appearance (Griffiths et al., 2014): the closer the individual feels to their ideal appearance, the higher their self-opinion will be, and the more distant the individual feels from their ideal appearance, the lower their self-opinion will be. However, one crucial difference between AN and MD is that individuals with AN may be forced into seeking treatment due to the faster deterioration of physical health, whereas individuals with MD often appear to be healthy as muscles are considered as a sign of good health (Leone et al., 2005). Therefore, MD's psychological and social consequences often remain untreated (Dawes & Mankin, 2004).

Although there are limited data on MD (Tod et al., 2016), epidemiological studies suggest that the number of men worldwide who meet the proposed diagnostic criteria for MD are estimated to be around 100,000 (Pope et al., 2000) and continues to increase (Leone et al., 2005). Tod et al. (2016) suggested that the average age of onset for MD is nineteen years old. However, Collins and Plahn (1988) found that boys' interest with increased muscularity starts as young as six or seven years old and increases until it peaks in early adulthood.

The increasing desire in men to become more muscular has also been observed across different countries. Frederick et al. (2007) found that young men in the United States, Ghana, and Ukraine reported dissatisfaction with their bodies and desired to be more muscular. Similarly, Adolescent boys in Fiji, Tonga and Australia also reported that they desired a more muscular body (McCabe et al., 2009). Additionally, pope et al. (2000)'s study on men from the United States, France and Austria found that men preferred to be 28 pounds more muscular than their average weight. These studies suggest that a considerable number of men across different countries are

dissatisfied with their appearance and desire a more muscular body. Although appearance dissatisfaction and a desire for muscularity do not necessarily indicate the presence of MD, they are significant predictors in the development of MD (Grieve, 2007).

Despite the increase in the prevalence of MD amongst men, there are currently no treatments developed specifically for MD. Previously, Mangweth et al. (2004) reported that the use of anti-depressants in combination with cognitive behavioural therapy has shown promising results. However, Leone et al., (2005) found two barriers to men's recovery from MD: lack of awareness by the individual suffering from MD and lack of recognition by professional care providers. These barriers highlight the importance of understanding the development of MD to improve prevention and intervention strategies.

Sociocultural theory and MD

The socio-cultural theory explores social and cultural influences such as beliefs, norms, age, and language to explain individuals' behaviours. This theory was initially developed by Vygotsky in the 1930s to highlight the role of culture and experiences on human behaviours (Stormer & Thompson, 1996). Vygotsky stressed that parents, peers, and social beliefs have an important role in individuals' development (Fallon, 1990). In the recent decade, there has been an increase in researchers' interest in the social influences of MD across different cultures (Tod et al., 2016; Murray & Rodgers, 2022). Thus, the socio-cultural theory has emerged as a key framework within which researchers explain the development of MD (see Dryer et al., 2016; Readdy et al., 2011; Olivardia, 2001). Researchers utilising the socio-cultural theory propose that men are exposed to several social pressures that reinforce muscular ideals (See Dryer et al., 2016;

Olivardia, 2001). These social pressures include the mass media, peers and family members (Dryer et al., 2016).

Mass media

As previously mentioned, the most influential of the social pressures that have been known to reinforce muscular ideals to men is the mass media, such as television and magazine, which portray increasingly difficult to attain bodies to men (Groesz et al., 2001). Although historically, it was believed that men are immune to the media's portrayal of out of reach bodies (see Drewnowski & Yee, 1987), over the past two decades, men have reported feeling pressured into attaining increasingly muscular ideals portrayed by the visual media (Pope et al., 2001). Grieve (2007) explained the media's role in men's body dissatisfaction and their increasing desire for a muscular body by highlighting the media's role in manipulating men's perception of physical attractiveness. According to Grieve (2007), as men are exposed to media ideals of attractiveness, they experience a contrast effect in which they will perceive their own body as less ideal.

Pope et al. (2001) examined the proportion of male body exposure in advertising magazines. Pope et al. (2001) concluded that the increase in fitness magazines that expose men to pictures of naked muscular men as a form of advertisement has led to men feeling dissatisfied with their bodies.

The media's role in reinforcing an ideal muscular body has also been observed in younger men. Stanford and McCabe (2005) utilised quantitative measures to evaluate the influence of social contributors such as the media on adolescents. Stanford and McCabe (2005) found that the increasing portrayal of muscular role models in the media directly influenced adolescent boys who felt pressured to gain muscles using weight training alongside anabolic steroid use.

Additionally, there has been a change in the portrayal of male role models (see: Grieve, 2007). For example, Sai and Yamauchi's (2022) literature review found that male action toys have become significantly more muscular over the past 20 years. Relatedly, Grieve et al.'s (2006) examination of behaviours related to body weight found that men became dissatisfied with their appearance after being exposed to magazines that had muscular male role models.

The social comparison theory and the self-objectification theory have been utilised by researchers to highlight the influence of media on men's experience of body dissatisfaction (see Grieve, 2007). Social comparison theory, originally proposed by Festinger (1954), suggests that individuals evaluate themselves by comparing themselves to others in traits that they deem important. In line with this theory, quantitative studies have found that exposure to media, particularly the advertising media, can trigger social comparison in men (Richins, 1991; Cahill & Mussap, 2007; Hobza et al., 2007; Jones, 2004; Karazsia & Crowther, 2008, 2009, 2010; Schaefer & Thompson, 2014). Grieve's (2007) etiological model suggested that men with MD may be comparing themselves to other men who are more muscular than them and thus, feel inadequately muscular. This feeling of being inadequately muscular compared to other men may lead to the experiences associated with MD, such as body dissatisfaction, low self-esteem and a drive for muscularity (Grieve, 2007).

The self-objectification theory was initially proposed by Fredrickson and Roberts (1997) to explain eating disorders in women. According to this theory, the media objectifies women by overemphasising their physical appearance. Consequently, women experience body image disturbance and eating disorders as they begin to evaluate themselves only in terms of their physical appearance.

Given that men are also influenced by the media's representation of an ideal male body (Lorenzen et al., 2004; Baird & Grieve, 2006), Grieve and Helmick's (2008) self-report measures found that men may also objectify themselves, leading to the development of MD. However, several other quantitative studies investigating self-objectification theory in men have found inconsistent results (e.g., Fredrickson et al., 1998; Hallsworth et al., 2005; Tiggemann & Kuring, 2004; Daniel & Bridges, 2010; Parent & Moradi, 2011).

Peers and family members

Despite the findings on the media's role in reinforcing muscular ideals to men, Karazsia and Crowther's (2009) quantitative study found that men are more likely to evaluate their appearance by comparing it to their peers rather than the models portrayed in the magazines. Furthermore, social influences such as family and friends have contributed to men's dissatisfaction with their appearance and their increasing desire for a more muscular body. For example, Liang et al. (2011) investigated the impact of childhood teasing on body image in adulthood and found that a substantial number of men reported being teased by their family and friends about their lack of muscularity.

Several other studies have found a link between childhood bullying and MD related constructs (see Tod et al., 2016). Autobiographies and single case studies of bodybuilders in the 1990s revealed that bodybuilders were bullied in their childhood for being weak (Fussell, 1991; Aycock, 1992; Klein, 1993; Wolke & Stanford, 1999). Wolke and Sapouna's (2008) cross-sectional study with a sample of 100 male bodybuilders examined the role of childhood bullying on MD and self-esteem. According to Wolke and Sapouna (2008), men who experienced

childhood bullying felt weak and small, which reduced their self-esteem and contributed to the development of MD. Moreover, a recent 14-year longitudinal research by Gattario et al. (2020) proposed that victimised children experience body dissatisfaction in childhood and throughout their adolescence and into adulthood. Gattario et al. (2020) found that childhood bullying (age ten years) predicted more negative body image in adolescence (age eighteen years), which in turn predicted more disordered eating in adulthood (age twenty-four years).

Masculinity

Although the above studies highlight the influence of media, peers and family members as contributors to the development of MD, none have mentioned the notion of masculinity in men's preoccupation with muscularity. Masculinity is a social construct that is believed to have a significant role in how men experience and respond to psychological problems (Connell & Messerschmidt, 1995). Pope et al. (2000) posited that adherence to traditionally masculine traits might influence men's behaviours associated with MD. The most idealised form of masculinity, as opposed to other forms of masculinities (e.g., homosexuality), is the hegemonic masculinity which is referred to as "the most honoured way of being a man" (Connell & Messerschmidt, 2005, p. 239). Hegemonic masculinity values power, confidence, strength, dominance, physical discipline, emotional self-control and sexual prowess (Smith & Mouzon, 2014). Therefore, men who endorse hegemonic masculinity consider these traits to be the characteristics of the ideal male (Connell & Messerschmidt, 1995). Adherence to hegemonic masculine norms has been associated with an increase in the desire for muscularity, body dissatisfaction and disordered behaviours linked to MD (see Griffiths et al., 2015). Pope et al. (2002) suggested that a high level of muscularity is how men express

their masculinity to others. Similarly, quantitative studies have found that men who adhere to hegemonic masculinity may pursue a muscular body to demonstrate masculine traits such as strength and sexual prowess (Blashill, 2011; Gattario et al., 2015; Griffiths et al., 2015; Mishkind et al., 1986). Relatedly, Drummond and Drummond's (2015) longitudinal focus group-based study found that five to ten-year-old boys experienced body dissatisfaction if they perceived muscularity as a masculine trait. On that note, Klein (1993) suggested that a muscular body allows men to hide unmasculine traits such as vulnerability and insecurity whilst displaying masculine traits of confidence and strength.

In addition to the above findings, the threatened masculinity theory was proposed to explain men's increasing dissatisfaction with their body size. (Mills & D'Alfonso, 2007; Mishkind et al., 1986). This theory posits that with the increase in gender equality in modern times and women's increasing accomplishments in the traditionally male-dominated domains, men experience an identity crisis. This identity crisis results from men's belief that the distinctions between them and women are disappearing, and a muscular body is their only option to distinguish themselves and emphasise their masculinity (Mills & D'Alfonso, 2007). Thus, pursuing a muscular body is men's attempt to distinguish themselves from the thin and fragile traits associated with femininity (Luciano, 2007, Mishkind et al., 1986, Pope et al., 2002).

The threatened masculinity theory is supported by Mills and D'Alfonso's (2007) experimental study that found when men failed in non-physical tasks against women, they were more likely to experience an increased desire for muscularity due to feeling inadequately masculine. Similarly, Beagain and saunders's (2005)

qualitative study found that men seek a body that resembles masculinity to distinguish themselves from women.

Hegemonic masculinity's role in the development of MD was also supported by a life history investigation of 20 men who experienced a dysfunctional preoccupation with muscularity (Edwards et al., 2017). Edwards et al. (2017) explored the stories of men who were preoccupied with muscularity and found that all men in their study shared a common narrative of experiencing childhood bullying, teasing and victimisation for being perceived as weak and small. These men discussed how their childhood experiences led to struggles with their masculine identity. As a result, they began to obsessively pursue muscularity to express hegemonic masculine traits.

Despite the hegemonic masculinity's contribution to men's pursuit of a muscular body, hegemonic masculinity also discourages men from being concerned about their appearance as that is considered weak and feminine (O'Gorman et al., 2020). Therefore, men are pressured into seeking a muscular body whilst feeling ashamed for being preoccupied with their appearance. This inner conflict in men is supported by Gill et al.'s (2005) qualitative study that interviewed 20 men about their appearances to explore their concerns. Gill et al. (2005) found that despite men's desire for a muscular body, they appeared unconcerned about their appearance to avoid the stigma of signifying feminine traits. Similarly, Hargreaves and Tiggemann (2006) investigated boys' and girls' responses to images of objectified bodies. They found that young boys cared more about their appearance than they were willing to admit because talking with their peers about appearance dissatisfaction was seen as a feminine trait.

The association of appearance concerns with femininity may explain men's reluctance to seek help for experiencing body image disturbances, as seeking help may indicate having appearance concerns (See Shepherd & Rickard, 2012). Relatedly, Grogan and Richards's (2002) exploratory study found that men keep their thoughts and worries about their appearance to themselves as they perceive discussions around appearance to be feminine and demasculinising. Moreover, a qualitative study carried out by De Souza and Ciclitira (2005) found that men are more likely to attribute their body image, diet and exercise to medical concerns to avoid stigma.

Conceptual models of MD and socio-cultural influences

Researchers utilising quantitative methodology positioned within a positivist paradigm have proposed conceptual models to explain the development of MD. For example, Olivardia (2001) proposed a biopsychosocial model that included social pressures such as media, peers and family as contributors to the development of MD. Cafri et al. (2005) extended Olivardia's (2005) model to investigate risky behaviours (e.g., steroid use) associated with MD and found that media was a risk factor that contributed to such risky behaviours. Grieve (2007) developed the previous models and proposed a complete biopsychosocial model that included a socioenvironmental category (media, sports participation) of contributors to the development of MD. Although in Grieve's (2007) model, the most important contributors to the development of MD were the psychological components (ideal body internalisation, body dissatisfaction and body distortion), Grieve (2007) explains that these psychological components are influenced by socio-cultural pressures. Grieve (2007) argues that a culturally ideal body (i.e.,

muscular) is communicated to men through peers, family and media. Thus, men internalise this ideal body, leading to body dissatisfaction and body distortion (Grieve, 2007). Grieve (2007) suggests that body dissatisfaction and body distortion have a reciprocal relationship: body dissatisfaction influences body distortion and body distortion exacerbates body dissatisfaction. This interaction between body dissatisfaction and body distortion brings about the behaviours associated with MD, which include strict dieting, extreme exercise, and steroid use (Grieve, 2007).

Previous research limitations

Muscle dysmorphia, a form of body image disturbance experienced primarily by men, is a neglected area of research. Existing research on MD is predominantly quantitative; however, such quantitative measures fail to capture the complexity and fluidity of MD and thus, may not apply to the everyday lived experiences of men (Hargreaves & Tiggemann, 2009). Tod et al. (2016) suggest that rigorous, in-depth qualitative studies, particularly life histories that explore childhood experiences, circumstances, and people that may have contributed to MD's development, are missing from the literature. Furthermore, Tod et al. (2016) suggest that studies that adopt a narrative approach to explore individual stories and lived experiences will help psychologists develop intervention strategies to change perceptions. Moreover, a limitation of previous research is the samples used to investigate MD. Previous research has recruited samples of undergraduates, competitive bodybuilders and steroid users (see Tod et al., 2016). Recruiting undergraduates makes the generalisation of data to the broader population of men who experience MD challenging (Blashill et al., 2020). Although competitive bodybuilders and steroid users share the same goal with those who experience MD (i.e., increasing

muscularity), it would be naive to assume that those who use steroids or partake in bodybuilding competitions suffer from MD (Suffolk et al., 2013). It must be noted that the main feature of MD is not the pursuit of increased muscularity but rather the dysfunctional preoccupation with a muscularity that interferes with daily life.

Furthermore, steroid users recruited from needle exchange settings may not disclose their authentic experiences due to the fear of stigma around steroid use (Griffiths, Murray & Mond, 2016). Therefore, to understand men's experiences of MD, it is imperative to capture the experiences of those who self-identify with the condition rather than those who display similar characteristics.

Current research

To the researcher's knowledge, the current study is the first to explore men's lived experience of MD. The present study aims to fill the gap in the literature by using IPA and narrative interview methodology to explore men's narratives of their lived experiences of MD. This approach allows the present study to explore common threads in MD narratives to improve the understanding of the links between culture, life history and the development of MD. Furthermore, exploring the experiences of men who have recovered from MD may contribute to improving prevention and intervention strategies.

METHODS

This chapter will begin by outlining the philosophical assumptions and underpinnings of this study. Furthermore, a detailed explanation of how qualitative methods aided in answering the research question will be provided. A section on the reflective statement will also be included in this chapter before I discuss the

recruitment process. This chapter will conclude with a detailed exposition of the data analysis process.

Philosophical underpinnings of the study

Epistemological position

According to Willing (2016) it is essential for researchers to define their assumptions about the nature of reality (ontology) and how one may come to know this reality (epistemology). This is because the researcher's ontological and epistemological assumptions will influence the study's direction and finding (Carter & Little, 2007). There are several different terminologies and classifications of epistemological theories (Fletcher, 2017). However, Willing (2013) insisted that less focus should be on the labels and more on the type of knowledge that the study aims to collect as this will influence the meaningfulness of the data and how it is collected.

In terms of epistemological position, the present study is influenced by contextualism. Contextualism views individuals in contexts (Larkin et al., 2006), and thus, considers knowledge to be dependent on contexts and perspectives as well as the researcher's position. This epistemological position assumes that human experiences are developmental and ever-changing in response to their environment (Jaeger & Rosnow, 1998). This fits with the present study's exploration of experiences by considering participants' past, present and changing contexts.

Ontological assumptions exist on a continuum, with relativism at one end assuming that reality is entirely dependent on human interpretations and a phenomenon can only be explored from multiple perspectives. At the other end is realism, which assumes an objective reality of a phenomenon exists and can be investigated by utilizing the appropriate research techniques. Between these two extreme positions and underpinned by the present study lies the position of critical

realism. Critical realism acknowledges the existence of an objective reality but stresses the need to consider individuals' perceptions and meaning-making to understand this reality (Willing, 2001). In relation to the present study, critical realism assumes that the participants' experiences of MD are real even if the participants are not aware of it. However, participants' interpretations of their experiences are influenced by their perceptions and cognitions, and thus, can only be partially accessed (Braun & Clark, 2013). Moreover, critical realism argues that a phenomenon is partially interpreted through language (Larking et al., 2006) and insists on the collaborative efforts of the researcher and the participant to engage in a meaning-making process (Smith et al., 2009).

In line with my epistemological and ontological positions, I believe that the participants' accounts of their experiences reflect their realities and exist in their own right. Still, I acknowledge that these accounts are influenced by the participants' perceptions and social context. Therefore, the knowledge obtained will be influenced by the participants' subjective interpretations and further translated by my interpretations. This position is consistent with the IPA approach as IPA accepts the existence of an objective reality, whilst acknowledging that this reality is influenced by individuals' perceptions, experiences, and context (Willing, 2013).

Table 1: The research framework

Ontological position	Critical realism
Epistemological position	Contextualism
Interpretive perspectives	Phenomenology, hermeneutics, ideography
Methodology	Qualitative, IPA

Data collection	Biographical Narrative Interview method (BNIM)
Participants	Men who have experienced Muscle dysmorphia

Interpretive phenomenological approach (IPA)

The Interpretive phenomenological approach (IPA) is a qualitative method developed in the mid-1990s (Smith, 1996) to explore individuals' lived experiences and how they make sense of those experiences (Smith et al., 2009). IPA was first developed in health psychology due to its suitability for exploring individuals' embodied experiences and the meanings assigned to them (Brocki & Wearden, 2006). Given that my aim was to explore the experiences of men with MD and the meanings they ascribed to their experiences, IPA was deemed to be the most suitable approach to address the aim of this study. IPA is founded upon three theoretical underpinnings: phenomenology, hermeneutics, and ideography (Smith et al., 2009). These philosophical underpinnings will be discussed in turn and how they inform IPA.

Phenomenology is an approach to study experience by identifying the essence of experiences or what makes experiences unique (Smith et al., 2009). The word phenomena refer to how things appear in individuals' consciousness (Smith et al., 2009). Smith et al. (2009) introduced four main phenomenologists as fundamental contributors to the phenomenological commitment of IPA: Husserl, Heidegger, Merleau-Ponty and Sartre. Husserl, known as the founding father of phenomenology, studied the very essence of experience (Shinebourne, 2011). For Husserl, this meant that we should move away from our natural tendency to fit

things into pre-existing categories and focus on the particular features of the experience in its own right (Smith et al., 2009).

Husserl, previously a mathematician, proposed the notion of 'bracketing', also known as *epoche* (Hartimo, 2006). Bracketing involves the researcher suspending their prior assumption and experiences about the phenomenon under study to allow the unique features of the phenomenon to shine (Smith et al., 2009). This bracketing, similar to bracketing in a mathematical equation, allows the data to be observed in its pure form. According to Husserl, this approach is the path to identifying the essence of a given phenomenon (Shinebourne, 2011). Husserl's exploratory nature of the phenomenological approach with its focus on experience (Smith et al., 2009) fits my aim of exploring the experiences of men with MD.

Heidegger, a philosophical student of Husserl, believed that Husserl's phenomenological approach was too transcendental (Smith et al., 2009) and questioned Husserl's approach at getting to the essence of human experiences (Heidegger, 1962). Heidegger viewed people as 'dasein' translated as 'beings-in-the-world' where they exist in a context of time, languages, cultures and relationships. To Heidegger, this entanglement with a pre-existing world would always be part of the human experience, and thus, complete bracketing would not be possible. In line with Heidegger's suggestion, IPA acknowledges the infeasibility of complete bracketing and promotes the reflexive role of the researcher that takes into account prior assumptions and experiences rather than attempting to fully eliminate them (Smith et al., 2009). Heidegger's stance is relevant to the present study as research suggests that the

fluidity of body image is the result of engagement within a personal and social world (Pope et al., 2000).

Merleau-ponty shared Heidegger's view of human beings as being-in-the-world with a context; however, he also emphasised the embodied nature of human beings in the world (Smith et al., 2009). Merleau-ponty believed that individuals' perceptions of the world and communications are always limited to their embodied perspective (Smith et al., 2009). In line with Merleau-Ponty, IPA views the body as a vehicle through which people experience the world (Smith et al., 2009). Such a view is particularly relevant to the present study as MD is experienced as an embodied sense of insufficient muscularity with cultural and personal layers of meaning (Tod et al., 2016; Blashill et al., 2020).

Sartre emphasises the developmental and evolving nature of human beings (Smith et al., 2009). To Sartre, the self is always becoming rather than an established entity waiting to be discovered (Smith et al., 2009). Furthermore, Sartre stressed the role of social relations in human experience as he believed that the presence or absence of others always shapes one's perception of the world (Smith et al., 2009). Sartre's contribution to IPA is relevant to the present study as men with MD often experience significant distress about how others view their bodies (Grieve, 2007). In short, IPA's phenomenological commitment is founded on the works of Husserl, Heidegger, Merleau-ponty and Sartre (Smith et al., 2009). Husserl highlighted the importance of focusing on the essence of experience and perception, whereas Heidegger, Merleau-ponty and Sartre emphasised the importance of seeing human beings as embodied and entangled in a world of language, people, relationships and cultures (Smith et al., 2009). This entanglement with the world requires moving away from Husserl's descriptive and

transcendental focus toward an interpretive approach to illuminate subjective experiences (Smith et al., 2009).

In IPA, one cannot directly explore experience but instead aims to be 'experience close' through the theory of interpretation or hermeneutics (Smith, 2011). Smith et al. (2009) referred to the work of Heidegger, Schieermarcher and Gadamer as the fundamental background to the theory of interpretation in IPA. This theory likens interpretation to an art or a craft that utilises various skills (e.g., Intuition) to offer insights into the author's intentions and the meanings that exceed the explicit content of the text (Smith et al., 2009). Thus, the researcher has an active interpretive role in IPA to make sense of the participants' lived world (Smith et al., 2009). This approach is also referred to as the dual interpretation process or 'double hermeneutics' as the researcher makes sense of the participant who is also making sense of their experiences (Smith et al., 2009). IPA unifies ideas from phenomenology and hermeneutics to adopt a descriptive method because it is concerned with how things appear (phenomena), and it is interpretive because it acknowledges that there is no such thing as an uninterpreted phenomenon (hermeneutics) (Smith et al., 2009). Smith et al. (2009) summarised IPA's unification of phenomenology and hermeneutics as follows: "without the phenomenology, there would be nothing to interpret, without the hermeneutics, the phenomenon would not be seen" (P.37). According to Smith et al. (2009), IPA's interpretive stance allows the researcher to deviate from the participants' words; however, as long as the interpretation is inspired by and tied to the participants' words, it is legitimate. Moreover, Smith et al. (2009) suggested that IPA interpretation may never end, and future interpretations may be possible; However, as this is neither practical nor desirable, a time comes when the

interpretation is 'good enough' to be written up. On that note, the present study's findings and interpretations will be presented as my 'stopping point' whilst I acknowledge that future interpretations might be possible.

The third major theoretical underpinning of IPA is its ideographic approach, which focuses on the 'particular' (Smith et al., 2009). This ideographic commitment works at two levels. Firstly, it focuses on the details to produce an in-depth analysis. Secondly, the ideographic approach focuses on the individual in a particular context (Smith et al., 2009). To adhere to its ideographic commitment, IPA recruits small and purposive samples in specific situations (Smith et al., 2009). Although this contrasts with the nomothetic approach, which aims at making general claims, IPA's ideographic commitment prescribes a different approach to generalisation (Smith et al., 2009). IPA argues that 'the particular underlies the universal' and that 'delving deeper into the particular takes us closer to the universal' (Warnock, 1987). The ideographic commitment of IPA was in line with the present study's focus on the subjective experiences of a small number of participants. According to Shaw (2001), the evolving nature of body image is a result of individuals' interaction with the personal and social context. Therefore, IPA's idiographic focus on the context makes IPA a suitable approach in exploring experiences related to body image (Shaw, 2001).

In essence, IPA is a holistic approach informed by its core principles rather than adhering to a single theorist (Smith et al., 2009). Furthermore, IPA is concerned with how individuals talk about their experiences and what the experiences mean to them, rather than describing experiences according to predetermined criteria or scientific theories (Smith et al., 1999). Thus, IPA requires the researcher to 'bracket' and acknowledge their presumptions to allow the

phenomena to speak for itself (Smith et al., 2009). Although IPA attempts to systematically and rigorously capture the participants' lived experiences and the meanings they ascribe to them, the analysis is the subjective interpretation of the analyst (Smith et al., 2009). Thus, different analysts may produce different interpretations. However, a good analysis requires the researcher to engage in the hermeneutic circle of moving from small parts and the whole of the transcript (Smith et al., 2009). For example, the interpretations of words are dependent on the context of the sentences, and the interpretations of the sentences are dependent on the context of the larger text (Smith et al., 2009). This constant shift between the smaller parts of the transcripts and the larger parts yields novel and insightful accounts of interpretations (Smith et al., 2009).

It is worth mentioning that the use of unstructured interviews in the present study fits with IPA's focus on the participant as it allows space for each participant's voice. Moreover, IPA is useful in gaining new insights into less researched topics as it does not aim to fit experiences into predefined categories (Smith et al., 2009). Therefore, IPA offered a flexible approach to exploring novel or complex questions. Additionally, the analytic stages provided a structure that is especially useful for me as a novice researcher (Smith et al., 2009).

Biographical Narrative Interview Method

The biographical Narrative Interview Method (BNIM) was specifically chosen for the present study due to its focus on collecting life narratives of individuals' lived experiences (Wengraf, 2001). BNIM is a form of qualitative data collection that was initially utilised in the 1970s to explore the experiences of holocaust survivors (Fischer-Rosenthal & Rosenthal, 1997) due to its suitability for collecting sensitive

life stories (Corbally & O’neill, 2014). BNIM’s data collection is most suitable for collecting rich qualitative data (Wengraf, 2001). Therefore, it is not recommended to use BNIM with large samples (Jones, 2003). Thus, BNIM was a suitable data collection method to obtain rich data from the present study’s relatively small sample size. In addition to data collection, BNIM has its own analysis process; however, it is possible to use BNIM solely for data collection and a different methodology for data analysis (Corbally & O’neill, 2014; Wengraf, 2001). The present study utilised BNIM (Wengraf, 2001) for data collection and IPA (Smith et al., 2009) for data analysis. To fully understand the process of BNIM’s data collection, the researcher must first comprehend the three sub-sessions of BNIM.

BNIM data collection consists of three sub-sessions. The first sub-session involves using a SQUIN (Single Question Used to Induce Narrative) (Wengraf, 2001). A SQUIN is a single question that is carefully designed to prompt the interviewee to narrate their story and experiences related to the research question (see Appendix A). During the interviewee’s response, the researcher becomes an active listener and does not interfere with the interview process with prompts or questions (Jones, 2003). As Wengraf (2001) pointed out, the process of active listening respects the participants’ individual voices. Furthermore, by refusing any offers of control, the researcher empowers the participant and minimises any power imbalances (Mooney, 2019). However, the researcher is permitted to take notes for the second sub-session (Wengraf, 2001).

Once the participant’s narrative in the first sub-session has ended, as indicated by the participant, the researcher can begin the process of the second sub-session after a short break. During this short break, the researcher will reflect on the participant’s story and studies his notes to formulate questions to obtain

further details. However, to maintain the participant's authority, the questions must be based on the participants' words and language. Moreover, to maintain the flow of the initial narrative, the questions must be presented chronologically, that is, in the order they came up during the first sub-session (Wengraf, 2001; Bradley, 2014).

The third sub-session allows the researcher to ask any unstructured questions related to the research question that did not emerge in the narrative (Wengraf, 2001). However, the third sub-session is considered an optional session, and the researcher can utilise sub-session one and sub-session two without the third sub-session (Wengraf, 2001). I did not utilise the third sub-session in the present study to maintain minimal influence and interference on the narratives provided by the participants.

This approach to data collection enables the participants to explore their own experiences of living with and recovering from MD. The risk with this approach is that the participant may go off-topic or avoid the research question due to discomfort (Mooney, 2021). However, Mooney (2021) suggests that the researcher can minimise this risk by designing a detailed and directive SQUID to induce a valuable narrative while not prescriptive to dictate a specific response.

Reflexive statement

Reflexivity is the researcher's continuous reflection during the research process upon their own beliefs, values, and experiences that may influence the study's interpretation and results (Willig, 2013). This continuous reflection allows the

researcher to acknowledge any pre-existing biases, interests and experiences to increase the study's credibility (Willig, 2013).

I begin to outline my assumptions and experiences related to the topic of this study in order to position myself within the study and to strengthen the study's rigour (willing, 2013). I am a 33-year-old male who has experienced MD since the age of 14 years old. I believe that my interest in the present study stems from my struggles with MD throughout my teenage years and my adult life. What has primarily prompted me to carry out this research is the lack of awareness about MD as a condition and lack of awareness about men's lived experiences of body image disturbances. Furthermore, it was particularly interesting to me when discussing my research ideas with peers in psychology, none had ever heard of MD, and it was when I referred to MD as the opposite of anorexia that it became more tangible. I found this lack of awareness about a condition that is primarily experienced by men alarming.

Prior to designing the interview schedules, I spent a considerable amount of time reviewing the existing literature on muscle dysmorphia, body dysmorphia and body image disturbances in men. This literature review provided me with general background knowledge about body image disturbances and eating disorders, whilst reminding me of my own experiences.

In order to manage my influence on the research, I exercised reflexive practices. Throughout the research process, I utilized a reflective journal to inspect my presumptions and bracket them to prevent impingement on the research. The journal contained a summary of my knowledge, experiences and a summary for each participant, including my initial impressions following the interviews (see Appendix B). Furthermore, I utilized supervision sessions to discuss how I interpreted the

participants' data to ensure the focus remained on the participants. Therefore, reading my reflective journal, regular supervisions, and a continuous inner dialogue helped me ensure that my interpretations were rooted in the data and not from a personal perspective. An example of this occurred when I interpreted the participants' words about their experiences of idolizing bodybuilders. The participants talked about looking up to bodybuilders as their role models, which led to negative consequences such as negative feelings towards their body image and steroid abuse. I interpreted this as participants' blame and condemnation of the bodybuilding community. However, during a discussion with supervisors and personal reflections, I realized that this had been my own experience and perspective, rather than the participant's lived experience. This was immediately noted in my reflective journal and thus, allowed me to direct my focus back to the participants lived experiences.

I have reflected upon whether my gender as a male may have impacted the data collection as previous research suggests that men wish to preserve their masculinity by not disclosing sensitive topics in the presence of other men (O'Brien et al., 2009). I found that the men in the study were open and willing to discuss sensitive topics with me.

Participants

One MD and one BDD support groups was identified on Facebook via an internet search. These were Muscle dysmorphia (Bigorexia, Reverse Anorexia) support group and Body Dysmorphic Disorder (BDD) discussion and support group. I contacted the group admins through their Facebook profiles. Two admins of the related support groups responded, communicated their interest in the project and asked for more information. I provided the relevant information about the study to the group admins, and they approved.

Following the approvals, each admin posted the research recruitment invitation (see Appendix C) on their groups and public pages. Within a week, five individuals contacted me via email and asked for further information regarding the study's aims and confidentiality. Three individuals met the recruitment criteria and volunteered to take part in the study. The sample size of three participants was in line with Smith et al.'s (2009) recommendation to researchers doing IPA for the first time. To ensure participants' anonymity, each participant was given a pseudonym which will be used when referring to them in the write-up. The participants' demographic information is presented in table 2.

Table 2: Participant demographics

Pseudonym	Age	Ethnicity
Craig	19	White/British
Chris	32	White/British
Matt	45	White/Irish

Data collection

Data was collected using the Biographical Narrative Interpretive Method (BNIM) technique (Wengraf, 2001). This interview method involved two sessions. During the first session, the participant was asked a single question. This single question, termed by Wengraf (2001) as a single question used to induce narrative (SQUIN), is a broad question designed to obtain uninterrupted data from the participant (see Appendix A).

The SQUIN starts by informing the participant about the research aims and asks them to share their life story or any significant experiences that they have had

related to the research question. Furthermore, the participants are informed that they can start from wherever they wish and that the researcher will only take notes for the second session (Wengraf, 2001). The SQUIN empowers the participant by allowing them to narrate and end the interview on their terms (Nicholson, 2009). Once the first interview session ended, as indicated by the participant, the participant and I took a 15-minute break. During the break, I reviewed my notes and formulated further questions to ask the participant in session two. However, the questions asked in session two were grounded in the participants' accounts in the first session and in the same timeline narrated by the participant. The questions from the second session allowed me to clarify specific details and obtain richer data. In line with Wengraf's (2001) recommendation, I also took background and situational notes during the interviews to enhance my memory of the interview's context during the analysis process (see Appendix B). The interviews took place on a video call using the Microsoft Teams app. Each interview was recorded using an audio recorder and lasted around two hours. The recordings were transcribed and saved in a password-protected folder and then deleted from the recorder.

Ethical consideration

Due to the personal and sensitive nature of the study, every effort was made to consider the ethical implications of the study and to adhere to the British Psychological Society's (BPS) code of human research (2021). Adherence to ethical guidelines is crucial as it instils confidence in the participants about the research. Participants' confidence in the research process is crucial for the collection of meaningful data (BPS, 2021). The ethical principles were maintained throughout the research process to protect the participants' rights and safety (Burles & Bally, 2018) and maintain the study's scientific integrity (Torrens & Castellano 2020). Ethical

approval was obtained from the University of Huddersfield's ethics board (see Appendix D). The ethics panel ensured that the research met the ethical guidelines prior to data collection and interactions with participants.

Participant recruitment began with a public message sent to two Facebook support groups related to MD (see Appendix C). The online message offered basic information about the study, such as the purpose of the study and what the study entailed. Before the interviews, each participant was given an information sheet that reminded them of the purpose of the study, what was involved, potential risks and how their data would be stored (see Appendix E). I made sure that the participants had read and understood the information sheet. I informed the participants verbally and in writing of their right to withdraw from the study at any time until the given date of analysis and provided them with consent forms (see Appendix F). The participants were also informed that their details and answers would be confidential and any identifying material such as names will be removed and replaced with a pseudonym. Furthermore, the participants were ensured that all the information collected from them would be kept secure, and only the researcher and the supervisors would have access to the data. The data will be stored in a password-protected folder on the researcher's private area of the university file storage system.

During the interviews, I remained sensitive to the possibility that the participants may experience distress by reliving past experiences. Therefore, I ensured that the interviews were conducted as respectful and sensitive as possible and reminded the participants to tell their stories in their own pace. After the interviews, I thanked the participants for their time and contributions to the study and provided them with debrief forms (see Appendix G). The debrief forms contained a list of relevant referrals and support available.

Lastly, I provided the participants with more information about their data. I informed the participants that although some direct quotes may be used in the final write-up of the study, any identifiable information will be removed to ensure anonymity. I informed the participants that audio recordings would be transferred from the recorder to a password-protected folder on a computer and deleted from the audio recorder. After the completion of the study, the data will be stored safely and in line with general data protection regulation (GDPR)' recommendations, passed to the main supervisor of the project to be kept in a safe password-protected folder for ten years. The data will be stored on a password protected electronic device and will only be accessed by the research team.

Analysis

The analysis was carried out using smith et al.'s (2009) guidelines and is outlined below:

Data transcription

I transcribed the audio recordings verbatim, removed any identifying materials such as names, and replaced them with pseudonyms and numbers. I made note of any non-verbal utterances such as long pauses, laughers and hesitations.

Furthermore, I left wide margins on the left and right sides of the transcripts to allow space for notes.

Reading and Re-reading

This was the first step of the data analysis. I immersed myself in the data by reading the transcripts multiple times and underlined interesting sentences and phrases until I was satisfied to be sufficiently familiar with the data, though some familiarity was achieved during the data transcription. Furthermore, as advised by Smith et al. (2009), I listened to the audio recording at least once whilst reading the

transcripts to help me imagine the participants' voices during the subsequent readings of the transcripts.

This stage enabled me to actively engage with the data and develop an overall understanding of the narrative structure. It is important to note that this stage of the analysis was concerned with slowing down and keeping the focus of the study on the participant, rather than summarizing the complex data in a short time (Smith et al., 2009). To ensure this, I also bracketed my initial observations and impressions of the interview experience by noting them in my journal (see Appendix B).

Initial noting

This stage aimed to produce detailed notes on the transcripts and to develop an understanding of the specific ways the participants talked and thought about their experiences. Before making notes on the participant's narrative, I read my reflexive journal on each participant to help me 'enter the world' of the participant. This stage also involved multiple readings of the transcripts to make exploratory and interpretive notes. At first, I made descriptive comments about the participants' descriptions of their experiences, followed by a more interrogative and interpretive approach. I started with reading the transcripts to make descriptive notes about what the participants described, such as events, relationships and experiences that seemed to matter to them. For example, during the descriptive noting of Matt's transcript, next to Matt's phrase "*I remember when I was young, I was very skinny*" (Matt, 1), I noted that being young and skinny is what Matt remembered about his youth.

Following this, I began to engage with the data in a more interrogative approach to make linguistic notes, which involved focusing on the language used by the participants, such as pauses, pronouns, repetitions, and metaphors. For example, I noted Matt's use of the first-person pronoun 'I' when reflecting on his experience of

being bullied for his body size but using the second person pronoun 'You' when referring to the consequences of those experiences such as trauma and self-hate. I noted that this may reveal Matt's desire to distance himself from the trauma and the self-hate he experienced as a result of being bullied.

I then moved on to read the transcripts at a conceptual level. This required me to move beyond the explicit contents of the transcripts to a more interpretive stance. For example, in reading Matt's description of whom he wanted to be: "I wanted to be respected as a man" (Matt, 30), I noted that this may reflect Matt's desire for an ideal masculine identity. It is also important to note that during the interpretive process of the analysis, on one level, I have had to draw on my personal experiences and knowledge to reflect on my understanding of the participants' experiences. On another level, I had to ask questions such as what would the experience be like? Who was the participant if they were not themselves? And are the participants' experiences time-related or embodied? As advised by Smith et al. (2009), I used the right side of the margin of the transcript for initial notes and the left side of the transcript margin for the emergent themes in the next stage of the analysis (see Appendix H).

Developing emergent themes

This stage aimed to reduce the volume of details from the transcripts and the initial notes to emergent themes. Themes are often expressed as phrases that tell us something about the participants perspective, what is important to them or a repeated pattern of meaning in the participants' words (Smith et al., 2009). The emergent themes represent not only the participants' words but also my interpretations of what seems crucial in the text. I aimed to ensure that the themes

are both grounded in the data and conceptual. This involved a move away from the transcript alone to work with the initial notes from the previous stage and to break down the narrative's flow into chunks of meaningful data for a closer inspection. For example, the theme 'trauma' emerged in reading my notes on Matt's description of being bullied for his body size. I wrote the emergent themes on the left side of the transcript margin and then typed them chronologically on a separate word document (see Appendix I). This process represents the hermeneutic circle where the whole data becomes a set of parts during the analysis before becoming a new whole in the write-up.

Searching for connections across emergent themes

This stage involved focusing on the emergent themes to produce a meaningful structure representing the participants' most important and interesting accounts. I started with eyeballing the typed themes to visually see how the themes may be related to each other. Next, I draw a mind map of themes relatedness and connections via lines to form clusters. For example, the themes trauma, self-hate, body-conscious, wimpy-kid formed a cluster that was termed 'struggling self' during the analysis of Matt's transcript. Themes that seemed disposable were discarded.

Whether a theme was relevant or discarded largely depended upon my overall research question. However, I anticipated that during the analysis of subsequent transcripts, I might come back and reevaluate the importance of the discarded themes. An example that I can refer to is the theme of 'idealised masculinity' which was discarded during the mapping of emergent themes in Matt's transcript. The theme of 'idealised masculinity' later reconnected to other similar themes such as 'personal expectations' and 'desiring confidence' as part of the reevaluating process.

This constant shift between the data and the themes allowed me to form additional clusters and decide what can be termed a superordinate theme. For instance, the themes 'muscle building as an escape', 'the ideal body' and 'a distorted image' formed the superordinate theme of 'the desire for muscularity. Some themes became a superordinate theme on their own as they brought together other relevant themes. For example, the theme 'the struggling self' was chosen as a superordinate theme that connected 'self-hate, 'trauma', and 'body-conscious' together. I also connected themes that were related to a specific event or time. For example, themes related to childhood experiences such as 'body-shamed, 'trauma', and 'alienation' were formed under a cluster termed childhood experiences. Taking note of such themes allowed me to notice if a similar pattern emerged during the analysis of the subsequent transcripts (see Appendix J).

Moving to the next case

I then moved to the next case and repeated the previous stages for each participant until I had a table of clustered themes and a mind map for each participant. I bracketed any ideas that emerged from the previous cases before moving to the next case to keep in line with IPA's idiographic commitment.

Looking for patterns across cases

During this stage, I laid out the participants' mind map and cluster of themes in front of me to look for patterns. This layout allowed me to see connections across the cases, themes that appeared to be dominant and themes that influenced the understanding of other themes. For example, I noticed a recurring pattern of negative feelings towards the self during the participants' description of childhood experiences. These negative feelings included self-blame, feeling isolated,

weakness, vulnerability, and defencelessness. Therefore, the sub-theme 'negative feelings towards the self' was formed. The theme 'idealised masculinity' helped clarify other themes that reflected participants' struggles with their masculinity such as 'associating muscles with confidence' and 'missing identity'. I drew the emerging patterns across the cases in form of clusters on a piece of paper. By doing so I was able to visually see the superordinate and subordinate themes and their connection to other relevant themes (see Appendix K).

Developing a narrative account

The final stage of the analysis involved producing a narrative account of the themes with data extracts from the transcripts.

FINDINGS

This chapter presents the findings of the interpretive phenomenological analysis of the three interviews. According to Smith et al. (2009), the researcher can choose one of two different approaches in presenting the analysis. One approach is the case within theme approach, where themes are presented, followed by supporting evidence from the participants. The other approach is the themes within the case approach, where participants are prioritized, and themes for each participant is presented together. Whichever approach is chosen to present the data analysis, the most important outcome is a clear narrative account of the researcher's interpretation of participants' experiences (Smith et al., 2009). For this study, I have found the first approach (case within themes) to be the most suitable approach to provide a clear narrative of the findings. This approach is most suited as the themes in the present study are chronological, and the best approach to represent that is through the prioritization of the themes. The occurrence of themes across the sample is presented in table 3.

Table 3: Identifying recurrent themes

Superordinate theme	Subordinate theme	Craig	Chris	matt
The struggling self	<i>"Weak, vulnerable and defenceless":</i> Negative feelings towards the self	√	√	√
	<i>"I wanted to be respected as a man"</i> Threatened masculinity	√	√	√
The desire for muscularity	<i>"Something in my head just really focused on my body"</i> Muscle building as an escape	√	√	√

	<i>"I am never big enough"</i> a distorted body image	√	√	√
Road to recovery	<i>"It got to the point where I couldn't do it anymore"</i> : Rock bottom	√		√
	<i>"It was probably just in my head"</i> : The power of perspective	√	√	√

In line with Smith et al. (2009), I present the findings in two parts. I start by providing a summary of the findings to give the reader a general sense of the data and the themes structure, followed by a detailed interpretive account of every theme with evidence from the participants' extracts.

Three superordinate themes of 'the struggling self', 'the desire for muscularity' and 'the road to recovery' emerged from the analysis of the interviews. These superordinate themes represent participants' narrative of their inner struggles at a young age to developing muscle dysmorphia and the journey of recovery in their adulthoods. I view the superordinate and subordinate themes as interrelated. Thus, I have produced a graphic representation to illustrate their interconnectedness.

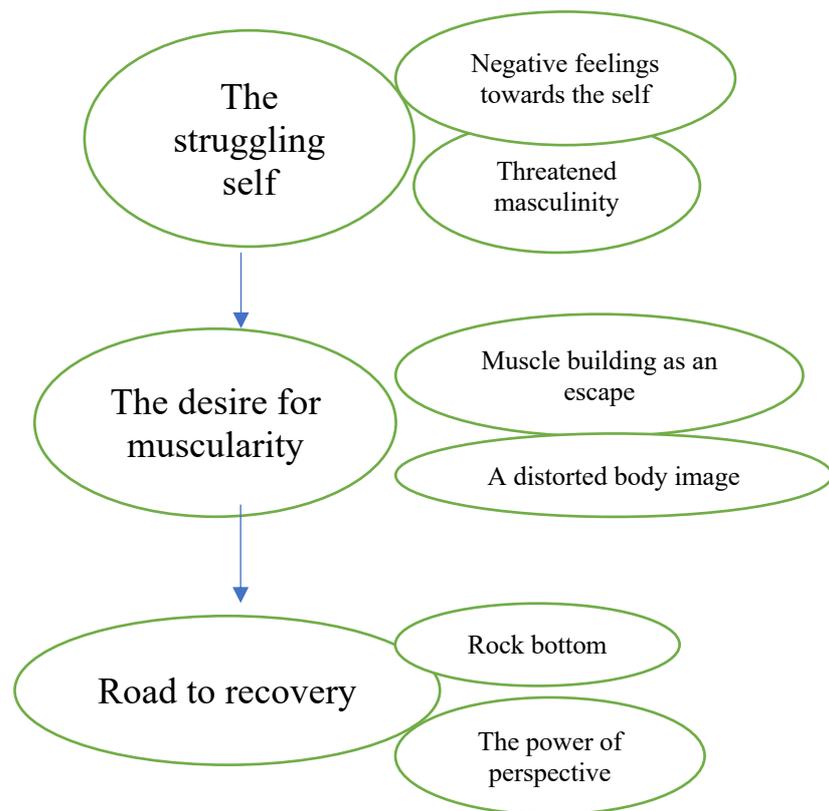


Figure 1: Superordinate and subordinate theme configuration

In the theme 'the struggling self', participants talked about their negative feelings towards themselves as a result of childhood experiences such as being labelled and bullied for their body size. These early experiences also influenced the participants' masculine identity. Therefore, the participants pursued a muscular body to reduce the negative feelings they experienced towards themselves and to express their masculine identity as muscles were considered a masculine symbol of strength and confidence.

'The desire for muscularity' theme represents participants' experiences of pursuing muscularity. In this theme, participants talked about pursuing muscularity as a coping strategy with psychological distress whilst experiencing a distorted body image. The

pursuit of muscularity combined with a distorted body image resulted in unhealthy behaviours such as over-eating, extreme exercise routines and steroid abuse. These unhealthy behaviours aimed at increasing muscularity led to negative physical consequences and, eventually, mental health deterioration. Participants described their experience of health consequences particularly mental health deterioration as a low point in their lives, referred to as rock bottom. However, this rock bottom experience was also the turning point in the participants' journey towards recovery as it prompted them to seek professional treatment. Therefore, rock bottom was included as a subordinate theme of 'road to recovery'.

The 'road to recovery' theme represents the participants' journey towards recovery from MD. In this theme, participants talked about their experiences of rock bottom and therapy. Rock bottom was referred to as an event that prompted the participants to seek help and therapy was discussed as a treatment option that allowed them to experience a shift in their perspectives. This shift in perspectives allowed the participants to see that they could be happy regardless of their body size and that their preoccupation with perceived flaws resulted from a distorted perception of their body size.

The Struggling Self

This superordinate theme reflects the participants' inner struggles with themselves and their masculine identity at a young age.

“Weak, vulnerable and defenceless”: Negative feelings towards the self

The participants talked about experiencing negative feelings towards themselves at a young age. This experience was a result of being bullied and labelled for their body size by their peers.

Matt described his experience of being bullied and labelled at a young age for being skinny:

"I remember when I was young, I was very skinny. I used to get bullied for it at school and even the kids around my neighbourhood. They had a name for me: 'the electrical skeleton'. Even my uncles and family members called me that. It used to get to me, you know, and the funny thing is that when they found out that it gets to me, they called me that every time they were pissed off with me. I think over time, this will create an issue in your head, and you just start hating yourself for it." (Matt, 1-6)

I find it interesting that Matt's first words in the interview were, *"I remember when I was young, I was very skinny"*, which indicates to me that Matt associates his youth with being skinny. For most people, childhood may be associated with fun times, playing, Christmas and so on; however, when Matt thinks of his childhood, he thinks of the time he was 'skinny'. Matt's association of his youth with body size reveals that this was a traumatic experience for him, which is also evident from the phrase, *"I think over time this will create an issue in your head"*. The word 'issue' here may refer to the trauma that had stayed with Matt long after those early experiences. Matt hates himself rather than his body because he experiences himself through the vehicle of his body. Therefore, for Matt, the experience of the body and the self were the same.

At the beginning of the extract, Matt uses first-person "I" to refer to himself when he was skinny and bullied. However, towards the end of the extract, when Matt talks about the consequences of the bullying (i.e., trauma and self-hate), he uses the second person, "you". This change from the first-person pronoun to second-person

pronoun may reveal Matt's desire to distance himself from the traumatised and hated self. Another interesting phrase in matt's extract is the label "electrical skeleton" that his peers and family used to refer to him, whether out of sarcasm or contempt. It seems that the word 'skeleton' may be referring to Matt's thin body; however, it is not clear why the word 'electrical' was added to it. Perhaps matt was highly charged and energetic. Nonetheless, the use of a label related to his body size was highly upsetting for Matt.

Chris also shares a similar experience of body image-related bullying. However, for Chris, the bullying and teasing were more related to his height rather than bodyweight, though the consequences were the same:

"My friends at the time started to pick on my appearance, I was quite short and skinny. I started getting teased because of my height, which made me feel weak, vulnerable and defenceless. I remember that's how me being conscious of my body started" (Chris, 23)

The words weak, vulnerable and defenceless reveal Chris's early impression of his body image. These words also indicate that the bullying Chris experienced may have also been physically threatening to him. These early experiences lead to Chris becoming 'conscious' of his body because he saw his body as a liability, as if the body provoked his friends to pick on him. Furthermore, the phrase 'my friends at the time' may be Chris's attempt at leaving those friends in the past to reassure himself that they no longer exist.

Craig's experience of being bullied was different to Matt and Chris in that it was online. Craig experienced online bullying in the early days of social media. When Craig found that his friends had joined social media, he too joined and uploaded his pictures. However, Craig received comments related to his body size:

“I remember when social media first came out, like Myspace. All my mates put their pictures on there, mainly to chat up the girls. It was like a dating site back then. So, I thought I put my pictures on there as well, even though I remember feeling not sure about it, but everyone else was doing, so I remember people commenting on my looks like, dude, why are your arms so skinny? Chicken legs... that’s when I wished I was bigger, and this just got more and more.” (Craig 121-126)

The above extract reveals Craig’s initial experience of social media, a platform where you can upload your pictures and chat with girls. Although Craig was ‘not sure’ about posting his pictures online as he felt insecure, he uploaded his pictures out of conformity to his friends. However, the comments Craig received on his image may have only served to exacerbate his insecurity. An important point in Craig's extract is that Craig began to idealise a bigger body following this incident, and this idealisation was not limited to the time of the incident. The phrase “and this just got more and more” reveals that this was only the start of a long-term obsession.

These extracts reveal the negative feelings participants experienced towards themselves at a young age as a result of being targeted for their body size. These negative feelings left a long-lasting impression on the participants’ body image.

“I wanted to be respected as a man” Threatened masculinity

Participants described their experiences of joining a gym to reduce their negative feelings towards themselves by transforming their bodies. However, I suspected that the participants may have also struggled with their masculine identity. This struggle is captured in Matt's description about why he joined the gym:

“I wanted to be respected as a man; I was tired of people looking at me like oh look at that wimpy kid, I wanted people to look at me and be like look at that tough guy, I would not want to mess with him!” (Matt, 30-33)

Matt's reason for joining a gym is not to be healthier or fitter, but rather it has to do with his identity as a man and how others perceive him. Matt may have believed that a muscular body would express his masculinity as it resembles toughness and demands respect. Thus, for Matt, a muscular body may represent traits that people would come to respect rather than confront. To further express this struggle with his masculine identity, Matt contrasts the “wimpy kid” with the “tough guy”. The wimpy kid is matt's perception of how others perceive him and represents his emasculated self, whereas the tough guy represents his idealised masculine self.

Chris's reasons for joining a gym also reflected his desire in acquiring masculine traits:

“So, I started to go to the gym at the age of 16 years old to become everything that I was not: strong, confident and muscular. I wanted to be the guy that other guys would look up to, and girls would want to be with” (Chris, 64-67)

Chris's early experiences of feeling weak, vulnerable and defenceless may have influenced his masculine identity. Thus, he believed that gaining muscle size may express his masculine identity as he viewed muscles, strength and confidence to be the traits of an ideal man. The phrase "the guy" here may represent Chris's idealized masculine identity that displays traits of strength and confidence, which attracts girls and is also idealised by other men.

This association of strength and confidence with muscle size is also evident in Craig's description of how he felt the very first time he walked into a gym and saw muscular men working out:

"It fascinated me, their strengths and sizes. These were big men walking around with bursting confidence." (Craig, 28-30)

Interestingly, when Craig talked about his first gym experience, what he noticed the most was the muscular men. For most people walking into a gym, the very first time may bring about a different experience. They may notice the different machines, how they operate, and people of all ages exercising. However, for Craig, it was the muscular men as muscle size was what he was most conscious of when he entered the gym, and thus, muscle size is the first thing he noticed. Furthermore, Craig idolised the 'big men' at the gym as they represented the masculine traits of strength and confidence.

These initial impressions of body image and the experience of threatened masculinity lay the foundation for the participants' pursuit of a muscular body.

The Desire for Muscularity

This superordinate theme represents participants lived experience of pursuing muscularity and includes subordinate themes of 'muscle building as an escape' and 'a distorted body image'. In this theme the participants talked about muscle building as an escape from distress, isolation and tensions within their family. Furthermore, the participants reflected on their distorted body image and unhealthy behaviours in their relentless pursuit of muscularity.

"Something in my head just really focused on my body": Muscle building as an escape

Participants discussed how working out and focusing on building muscles temporarily helped them to tune out their psychological distresses. This psychological escape is reflected in Chris's description of how going to the gym to work out helped him temporarily focus on the weights rather than his anxiety and depression:

"When I walk in the gym, I will leave all my troubles outside the door and pick it back up when I walk out of the gym. I would be so focused on the weights and the pain in my muscles that I forget about being depressed or anxious. The gym is my temple, and the weights are my therapy." (Chris, 117-120)

The keywords in Chris's extract are 'temple' and 'therapy'. The word 'temple' indicates that for Chris, the gym may not just be a place for fitness and health, but

rather a sanctuary. This sanctuary offers Chris a temporary relief from psychological pain by replacing it with temporary physical pain. The replacement of psychological pain with physical pain indicates that the psychological pain of anxiety and depression may have been much more overbearing for Chris than the physical muscle pain he experienced at the gym. Although Chris viewed this interaction with the weights as a form of therapy, the phrase “pick it back up when I walk out of the door”, indicates that this temporary relief offered no long-term solution and he merely ‘forgets’ his anxiety and depression rather than seeking long-term professional treatments.

Similarly, for Matt working out was an attempt to focus on his body rather than his psychological distresses:

“At the time, I thought I had found a passion, but thinking back on it now, I realise that most of these obsessions around my body were a way to distract myself from all the troubles in my head caused by all the tensions in my family... you know I would not get on with my dad... he was overly criticising of me, especially compared to my younger brother... I just felt like I am constantly tense... so, working out... focusing on my body was I guess a way of distracting myself from it all like I am doing something good” (matt, 158-164)

Matt’s misinterpretation of “obsession” with “passion” may be due to the feeling that he is “doing something good” when working out excessively. However, it becomes apparent for him when he reflects on his experiences that his obsessions with his body only served as a distraction from distress. Matt referred to ‘all the troubles in his

head' and 'all the tensions in his family', but without clarifying any of these, he singled out his dysfunctional relationship with his father. It is as if, for him, the stressful relationship with his father was just as equal to all the other distress he was experiencing. Furthermore, the experience of his father's criticism may have exacerbated Matt's inner struggles due to expectations he felt he could not meet. Therefore, merely escaping was not enough for Matt as he also needed to counteract his father's criticism by feeling good about himself. Therefore, focusing on his body and building muscles not only offered Matt an escape from distress, but also a difficult task that made him feel good about himself.

For Craig, muscle building was an escape from the alienation and isolation he experienced at a young age when he moved with his family from a small village to a large city. This period was a challenging time for Craig in which he finds himself focusing on his body to tune out his uncertainties:

"This [obsessions with muscle building] started when my family moved from a small village to the city. This, for me, was a massive change. Everyone looked so different to me, so much more intelligent, better looking and more popular. Then something in my head just really focused on changing my body so... I felt like when I am at the gym working on my muscles, I'm not bothered about everyone else." (Craig, 15-19)

The phrase "*This for me was a massive change*" reflects Craigs struggle to adapt to this new environment. Thus, he begins to feel alienated: "*Everyone looked so different to me*". The experience of alienation may have led Craig to evaluate others as better than him in traits that he considered vital for being accepted: (i.e., looks,

intelligence and popularity). As a result of this evaluation, Craig may have felt overwhelmed by a sense of lack of external control, and thus, by focusing internally (i.e., the body), he may have attempted to seize back a sense of control that he felt he had lost in the transition to the new environment.

“I am never big enough” a distorted body image

During the participants' talks about their desire for a muscular body, it becomes apparent that this pursuit of muscularity does not have an end goal, and no matter how muscular they become, they would still see themselves as flawed and small. This indicates that the participants may have experienced a distorted body image. This distortion of body image is experienced by the participant as a subjective feeling of being weak or small despite extensively evaluating their body in the mirror, observing increased weight on a scale, and receiving external compliments for their body.

Matt's distorted body image is reflected in his description of how he assessed his body by spending hours in front of the mirror and taking hundreds of pictures, looking for flaws:

“I would spend so many hours in front of the mirror looking at my weak body parts and even take hundreds of pictures... then I would think right! I need more calories because to me if I am not big enough, I am either not eating enough or not training hard enough... there was never an end to this though because I'm never big enough, to the point where your body just can't take it anymore” (Matt, 168-171)

Matt's distorted body image, no matter how many hours he spent in front of the mirror or how many pictures he takes of himself, always led to unhealthy eating and workout patterns because he only saw flaws and weaknesses. For Matt, spending many hours in front of the mirror and taking hundreds of pictures may have been ritualistic behaviours aimed at easing his anxieties. Perhaps, Matt would be anxiously staring at himself, looking for solutions to weaknesses. However, it would always end with increasing calories and workout intensity as the flaw was always about being insufficiently muscular. The phrase "*looking at my weak body parts*" indicates that when Matt looked at himself in the mirror, he did not see a whole self, but rather, he saw himself as many different parts. Furthermore, Matt recognises that as long as he perceived his body as insufficiently muscular, he would be constantly pushing his body. Despite all these, Matt acknowledged that his human body has its limits.

However, for Craig, there was no limit:

"I was still feeling small even when I reached 120kg. I felt like my health was suffering, my breathing was heavy, I had liver and kidney inflammations, thick blood. All of that meant nothing to me because there was nothing worse than being small. I even told myself that I would rather die big than to live small." (Craig, 372-376)

Craig's extract reveals the extreme and devastating experience of MD for the person living with the condition. Craig was feeling the weight of this burden on his body, but not only this was not a cause for concern for him, but the fear of being small was more challenging for him to bear than potentially facing death. The phrase "I was still

feeling small even when I reached 120kg” is interesting as it revealed the subjective nature of MD. This subjectiveness means that although Craig may have known that 120kg was not objectively considered small, he still ‘feels’ small. Therefore, regardless of any external confirmation to suggest that Craig is not small, so long as Craig ‘feels’ small, he may still pursue more muscularity, despite the risk to his health.

This subjective nature of a distorted body is also evident in Chris’s extract:

“I was never happy, people would compliment me like oh nice arms, and then automatically I be like yeah, but my legs are too small. It’s like I didn’t have the confidence to accept the compliment and just focused on the negatives.” (Chris, 203-206)

Chris’s extract reveals that preoccupation with muscularity can also be specific to a body part rather than whole body. For Chris, even if he received a compliment for a body part, he would still focus on the body part that he perceived to be small.

Therefore, compliments do not mean much reassurance for Chris as his attention is quickly diverted to perceived flaws. Thus, Chris experiences a distorted body image as a heightened focus on his perceived ‘negatives’, even in the face of external compliments.

These extracts, particularly Craig and Chris’s extracts, revealed that the men in the study judged their body size as small even in the face of external suggestions to the contrary. Thus, no amount of mirror checking, compliment or numbers on a scale relieved the participants from not feeling small and weak. This experience of a

distorted body image combined with the pursuit of a muscular body contributed to behaviours such as force-feeding, extreme exercise routines, and steroids abuse. Engagement in these unhealthy behaviours inevitably led to deterioration of physical and mental health. These health consequences eventually led to a crisis period referred to as 'rock bottom' which was also a turning point in the participants journey towards recovery. Therefore, the experience of 'rock bottom' was included as sub-theme under 'road to recovery'.

Road to Recovery

This superordinate theme explores participants journey towards recovery and includes subordinate themes of 'rock bottom' and 'the power of perspective'. In the 'rock bottom' theme, two participants talked about experiencing a mental health breakdown after ignoring the physical consequences of their extreme lifestyles. One participant was more fortunate to be encouraged by a friend to seek professional help before reaching that breaking point. In 'the power of perspective' theme, the participants talked about their experiences of receiving professional support in the form of therapy sessions, during which they began to experience a shift in their perspectives. This new shift in perspectives helped the participants to manage their distorted body image to lead healthier lives.

"It got to the point where I couldn't do it anymore": Rock bottom

Craig and Matt experienced a rock bottom period where they found themselves unable to continue with their extreme lifestyles due to the toll it took on their mental health. Craig described how force-feeding, extreme exercise patterns and steroid use led to him experiencing digestive issues, fatigue and ultimately depression:

"This went on until I got physically sick. I found myself exhausted all the time. I could not eat, I had no appetite, I started to have digestive problems. I knew there was something wrong. At first, I thought it was temporary and I should carry on no matter what. But when I found myself literally dragging myself out of the bed and in the gym, I thought right it's time to take a break. Even my mood was effected, I lost motivation, I was depressed, and it just went downhill from there. I was having panic attacks on a daily basis. It got to the point where I had to go and see a doctor. I went to the doctor, and he referred me to a psychiatrist." (Craig, 391-399)

The phrase *"At first, I thought it was temporary, and I should carry on no matter what"* gives us a glimpse into Craig's worldview where he would carry on eating many calories despite experiencing digestive issues. In the previous theme, we see a similar worldview in Craig's inner dialogue with himself: *"I even told myself that I would rather die big than to live small"*. It is perhaps this extreme worldview that prevents Craig from listening to his body until his body fails him. Furthermore, Craig may have not anticipated that his energy, mood, and motivation would also be diminished. This lack of anticipation is reflected in the words *"I found myself"* and *"Even my mood"* when Craig talks about his lack of energy and mood. These phrases may also indicate that Craig was acting without agency or conscious awareness. The word *"downhill"* reflects Craig's journey from where he thought he was on top to rock bottom, where daily panic attacks occur. If the threat of physical health deterioration did not compel Craig to seek help, the mental health crisis did. Thus, this is the turning point in Craig's living experience of MD as it puts him on the path towards seeking professional treatment.

Matt's steroid abuse led to him experiencing side effects. However, despite the side effects, Matt found it extremely difficult to stop the steroids as he believed that would cause him to lose muscle size. Thus, Matt tried to live with the side effects until he reached a breaking point:

"It got to the point where I couldn't do it anymore, and I felt so depressed I didn't even know who I was anymore. I stayed in bed for weeks and did not answer any phone calls. I did not feel like eating or even showering, I just be thinking what's the point of life? This is when I hit rock bottom. So, I ended up in a and e with my family next to me crying." (Matt 244-248)

Matt finds himself unable to pursue his muscular obsession due to steroids' side effects. This inability to continue using steroids to increase muscularity led to the experience of depression and a sense of identity crisis. Matt was depressed because he may have realized that this was not a sustainable lifestyle and he experienced an identity crisis because bodybuilding was his identity: "my identity was this guy who was a dedicated bodybuilder" (Matt, 157-158). The phrase "*I just be thinking what's the point of life?*" reflects Matt's existential crisis in which he is questioning his life's value and purpose. Matt described this experience as the rock bottom that landed him in the hospital's emergency department, however, he does not disclose how this had happened. Perhaps Matt attempted to take his own life, and he was ashamed to talk about it as the phrase "*with my family next to me crying*" indicates the seriousness of the matter.

Chris also experienced a low point during which he becomes concerned about his health. However, unlike Matt and Craig, Chris seeks the advice of a close friend:

“When I spoke to my friend about my thoughts and health, he encouraged me to see a doctor, and that was the most important thing I have ever done in my life” (Chris, 329-330)

Chris’s disclosure of his thoughts and concerns about his health with a friend may reflect his attempt at seeking help. Perhaps Chris would have experienced more significant physical and mental health consequences were it not for his disclosure of concerns and friend’s advice to seek professional help. Therefore, Chris’s extract reveals the value of being able to talk about sensitive issues and receiving constructive advice in recovery from MD.

“It was probably just in my head”: the power of Perspective

This theme reflects the participants' attempts at making sense of their experiences during recovery from MD. Once the participants received treatment such as therapy, they began to see how their preoccupation with their perceived flaws shaped their thinking. Participants talked about acquiring new perspectives and insights into their own beliefs during their therapy sessions. Thus, participants considered perspective as a valuable tool that allowed them to see the perceived flaws in their appearances as their own distorted perceptions.

During therapy, Craig was able to better reflect on his experiences of body image and realize that contrary to what he had always believed, his happiness did not depend on his muscle size:

“When I could see the bigger picture of how my body image moved, I realized that it was mostly in my head, that if only I had 22inch arms or massive legs, I would be happy. This is when slowly, over time I started to see things more clearly. I started to believe that I could be happy without any of these” (Craig, 440-448)

The phrase “the bigger picture” may refer to Craig’s reflection on his experiences retrospectively. This retrospective reflection allowed Craig to notice how his preoccupations were temporary as they moved from one body part to another. Therefore, reflecting on the temporary nature of his preoccupations with muscularity allowed Craig to conclude that his perceived lack of muscularity was the result of a distorted perspective. Although this bigger picture is not very clear for Craig at the start of therapy, it becomes clearer with subsequent sessions, and ultimately, leads to an important goal in recovery, which is the belief that he can be happy regardless of his muscle size.

Similarly, for Matt, this change of perspective happens when he reflects on his body image experiences during his therapy sessions:

“When I could see how my body image comes when I’m down and goes when I am happy, I thought that it was probably just in my head. Nobody cared if I looked skinny” (Matt, 285-286)

Here we get a glimpse of the reason for Matt's change of perspective "nobody cared if I looked skinny". When Matt was preoccupied with his size and body image, he believed that so was everybody else. However, when he was not preoccupied with his body image, he did not entertain such thoughts. Thus, Matt concluded that his preoccupations were his subjective perception rather than an external reality.

Furthermore, during Matt's reflections in therapy, he realized that his preoccupations with muscularity were mostly due to his mood: if he were sad or anxious, he would believe that he is small; however, if he were in a happy mood, he was not preoccupied with such distorted thoughts. This realization led Matt to conclude that if his perceived flaws were as real as he perceived them to be, it would not depend on his mood.

Chris also talked about experiencing a shift in his perspective as a result of attending therapy sessions:

"I was finally able to see things differently. That's when I found out the power of the mind. The world seemed different, I seemed different, but nothing had changed outside or with my body, in fact, at this point, I had lost a lot of muscles because I wasn't forcing myself anymore... but... I was ok. Like a born again feeling" (Chris, 346-357)

Chris's change of perspective influenced how he viewed himself and the world around him. During Chris's struggles with MD, he may have never seen a day where he would look at himself with less muscles and feel ok. Therefore, he is amazed at

“the power of the mind” when he is able to feel ok despite the loss of muscle size. This ‘ok’ feeling is a “born again” feeling for Chris as he has always struggled to feel ‘ok’ with his body size. Thus, it is as if he has been given a new life in which happiness does not depend on muscle size. Furthermore, this new perspective prevents Chris to repeat previous behaviours despite losing muscle size.

In short, forming new perspectives served as a psychological tool that facilitated the participants’ journey into long term recovery from MD.

DISCUSSION

This chapter presents a summary of the study’s findings; discusses the findings in relation to the literature; highlights the study’s limitations and considers the study’s contributions to future research and practice. The purpose of the present study was to understand the lived experiences of men with MD. As mentioned in the previous chapters, IPA recruits small and purposive samples in specific situations. This approach allowed the present study to obtain rich, in-depth accounts of three men with the experience of MD. However, it is important to note that the accounts in this study were not intended to reflect a representative sample of all men who have experienced MD but to help open discourse for future research.

Using IPA, this study shed light on the experiences of three men who had experienced MD at some point in their lives. Since this study was focused on men who had recovered from MD, all three participants had been able to seek help and get better. The findings revealed men’s experiences of childhood bullying, isolation, family tensions and struggles with masculine identity at a young age. The participants pursued a muscular body to feel better about themselves. Furthermore, a muscular body resembled masculine traits that the participants believed they

lacked, such as strength and confidence. Additionally, muscle-building provided the participants with a sense of escape from their psychological struggles; however, the participants also experienced a distorted body image.

The pursuit of a muscular body alongside a distorted body image meant that no matter how much muscle the participants gained, they still felt small, which gave rise to excessive and risky behaviours. These behaviours included overeating, excessive exercise routines and steroid abuse that eventually led to the deterioration of physical health in this study. Despite the physical health consequences, the participants felt unable to stop pursuing an unrealistic muscular body until they experienced mental health consequences. The experience of mental health consequences was the turning point in the participants lives as it compelled two participants to seek professional treatment and one participant to talk to a friend who was also encouraged to seek professional treatment. The participants talked about receiving therapy which helped them to reflect on their experiences and adopt a healthier perspective of their body image. The findings of the study are discussed in relation to the existing literature. Due to the nature of IPA that yields unanticipated and unexpected findings (Smith et al., 2009), it was necessary to introduce theories and studies that were not discussed in the introduction. This is a common practice in IPA (Smith et al., 2009).

The present study provides support for the literature by revealing that the participants perceived themselves to be smaller than they appeared (see Tod et al., 2016). Furthermore, the participants in this study indicated MD related behaviours and attitudes that were previously outlined by Grieve (2007). Attitudes amongst men in this study included dissatisfaction with their body size and desire for increased muscularity, whilst behaviours included the consumption of large quantities of food,

rigorous weight training and anabolic steroid abuse. In line with the literature (Phillips, 1998; Olivardia, 2001; Pope et al., 1997), one participant reported 'repeated mirror checking' behaviour by stating that he would spend many hours in front of the mirror to evaluate his body. The present study adds to the literature on MD by demonstrating that picture taking can be another form of 'mirror checking' behaviour aimed at locating flaws and weaknesses. One participant reported that he took as many as a hundred pictures of himself to check for flaws.

Previous studies on body image disturbances suggested that men view and experience dissatisfaction with their body as a whole, compared to women who experience dissatisfaction with specific body parts (Lantz, Rhea and Mayhew, 2001). However, in the present study, one participant reported using the mirror to check for weak body parts, whilst another participant reported dissatisfaction with a specific body part (i.e., legs). Therefore, the present findings contradict the previous suggestion as it found that men may also view their bodies as different parts and experience dissatisfaction with specific body parts.

The present findings support the socio-cultural theory as a framework within which the social and cultural influences of MD can be explored. The findings revealed socio-cultural influences such as peers, family, and the notion of masculinity influenced the participants' body dissatisfaction, self-esteem and identity as men. Previous studies highlighted mass media as the most influential communicator of an unrealistic ideal body to men. However, the participants in the present study did not talk about media as their source of influence on their body image.

The present study found that peer bullying during childhood influenced the participants' body image, self-esteem and masculine identity. These Early experiences made the participants feel weak, small, defenceless and vulnerable.

According to King (1997), these feelings reflect individuals' low self-esteem. Therefore, the present findings indicate that childhood bullying related to body size reduced the participants' self-esteem. This finding is supported by Wolke and Sapouna's (2008) study that found feeling inadequately muscular as a result of being a victim of childhood bullying significantly reduced men's self-esteem.

The experiences of early childhood bullying reported by the men in the present study may have contributed to their struggles with body image long after the childhood experiences. This finding is consistent with previous studies that found children exposed to bullying related to body size experienced low self-esteem, body image disturbances and mood disorders long after the initial experience (see Wolke & Sapouna, 2008). For example, Eisenberg et al. (2003) found that schoolchildren who experienced bullying related to their weight reported low body satisfaction, low self-esteem, and depressive thoughts long after being bullied. Similarly, deLara (2019) investigated the long-term consequences of childhood bullying and found that bullied children struggled with self-esteem and body image well into adulthood.

The participants in this study reported that the bullying they experienced made them feel weak and vulnerable and thus, pursued a muscular body to feel strong and confident. Given that strength and confidence are key features of hegemonic masculinity (Speer, 2001; Ricciardelli et al., 2010), the present findings suggest that in addition to low self-esteem, being victims of childhood bullying may have also influenced the participants' masculine identity. The link between childhood bullying and masculine identity is supported by Rosen and Nofziger's (2019) study, which suggested that bullying reinforces traits associated with hegemonic masculinity (i.e., boys who did not demonstrate hegemonic masculinity traits in size and appearance such as strength and muscularity were targeted by their peers). The present findings

concur with previous studies on the link between childhood bullying and MD (Fussell, 1991; Aycock, 1992; Klein, 1993; Wolke & Stanford, 1999).

The present study found that family members such as the father had also influenced men's preoccupation with muscularity. One participant reported focusing on muscle building as an escape from his father's criticism. This is supported by Edwards et al. (2017)'s study that used a narrative life approach to explore how men talk about their early experiences that influenced their excessive preoccupation with muscularity. Edwards et al. (2007) found that men who experienced dysfunctional relationships with their fathers and were exposed to their father's criticism focused on muscle building when they felt that they could not meet standards set by their fathers. In addition to peers and father as a family member, the present study found that social isolation also influenced men's preoccupation with muscularity. One participant reported that he focused on his body to distract himself from the isolation he experienced following his transition from a small village to a larger city. Fussell (1991) noted that moving to a larger city can lead to the pursuit of muscularity to compensate for the feeling of being physically vulnerable.

Grieve's (2007) biopsychosocial model of MD suggested that psychological components such as ideal body internalization, body dissatisfaction and body distortion are the most important contributors to the development and maintenance of MD. Ideal body internalization was defined as peers, family and media's communicated expectation of a muscular body. Although the men in the present study did not talk about media as their source of ideal body internalization, they internalized an ideal body (i.e., muscular) through their early interaction with peers. This internalization may have occurred as a result of peer bullying that reinforced the expectation of a muscular body to the participants. Therefore, the current findings

are consistent with Karazsia and Crowther (2009), who suggested that men are more likely to internalize an ideal body through their interactions with their peers rather than through exposure to media.

Furthermore, the participants' experience of body dissatisfaction as a result of internalizing an ideal body is in line with Grieve (2007)'s model that suggests ideal body internalization directly influences body dissatisfaction. Additionally, Grieve (2007) suggested that body dissatisfaction and body distortion have a reciprocal relationship in which body dissatisfaction influences body distortion, and body distortion exacerbates body dissatisfaction. Although this relationship is not clear in the present study, the participants reported experiencing dissatisfaction during their early experiences and a distorted body image during their experiences of pursuing a muscular body.

The participants in the present study experienced dissatisfaction with their bodies and masculinity whilst desiring a muscular body. The current finding suggests that the participants experienced a discrepancy between their perceived self (i.e., insufficiently muscular) and their ideal self (i.e., muscular), resulting in body dissatisfaction and behaviours aimed at increasing muscularity. Social psychology has a rich history of investigating how people's self-concept influences their emotions and behaviours (Cast, 2003). The self-discrepancy theory proposed by Higgins (1987) posits that when individuals experience a discrepancy between their actual self and their ideal self, they experience emotions such as dissatisfaction and disappointment. Furthermore, the greater the perceived discrepancy, the greater the degree of such emotions will be experienced. Higgins (1987) suggested that this emotional reaction is due to the individual perceiving this discrepancy as a failure in fulfilling their hopes and desires.

Several studies have used the discrepancy theory in the context of body image disturbances (Forston & Stanton, 1992; Higgins et al., 1992; Strauman & Glenberg, 1994; Strauman et al., 1991). However, most studies have used the self-discrepancy theory to explain the development of body image disturbances in women (see Vartanian, 2012). These studies explain that when women perceive that their actual body does not match their ideal thin body, they experience body dissatisfaction (e.g., Cash & Green, 1986), bulimia (e.g., Snyder, 1998) and anorexic behaviours (Higgins et al., 1992). Although most studies of self-discrepancy and body image disturbance have used female samples, experimental studies have found that when men are exposed to images of muscular men, they experience a high degree of self-discrepancy and eat more food than other men (see Vartanian, 2012). Moreover, Vartanian (2012) suggests that when men experience a discrepancy between their actual self and ideal self, they engage in exercise and dieting behaviours to increase muscularity. The present findings are in line with previous research on body image related discrepancies. The participants in the present study experienced a discrepancy between their perceived self (i.e., weak, small and vulnerable) and their ideal self (i.e., strong, muscular and confident). This discrepancy led to dissatisfaction with their perceived bodies and masculinity. In response to the discrepancy between their perceived self and their ideal self, the participants reported that they engaged in behaviours (such as diet and exercise) aimed at increasing muscularity.

Another theory utilized to explain body dissatisfaction in men is the threatened masculinity theory (Mills & D'alfonso, 2007; Mishkind et al., 1986). As mentioned earlier, the threatened masculinity theory was initially proposed to explain that the increasing body dissatisfaction in men is the result of a masculine identity crisis due

to the increase in gender equality in western cultures (Ryan et al., 2010). According to the threatened masculinity theory, men pursue a muscular body to emphasise their masculinity and differentiate themselves from women (Hunt et al., 2013).

Although the participants in the present study did not overtly compare themselves to women, they desired a masculine self when they felt associated with feminine traits such as thinness and vulnerability. Therefore, one can argue that men's experience of threatened masculinity may not be solely due to feeling inadequate compared to women, but rather whenever they feel associated with feminine traits.

Participants in the present study talked about muscle building as a temporary escape from psychological distress. Baumeister (1990) proposed the escape theory to explain individuals' tendency to engage in behaviours that enables them to escape the psychological distress caused by their self and ideal discrepancy. The escape theory posits that when individuals perceive that their self-concept does not match their ideal self, they experience psychological distress. To flee from this psychological distress, they narrow their focus to their immediate environment and engage in behaviours that offer them an escape. Although these behaviours provide a temporary relief or distraction to the individual, they often result in adverse consequences.

The escape theory consists of six stages: first, the person has a distressing experience in which he realizes that he falls short of his own or others' expectations. Second, the person blames this shortfall on themselves rather than on external influences. Third, the person notes that this shortfall portrays the self as unattractive. Forth, the person experiences psychological distress as a result of this realization. Fifth, the person seeks to escape this psychological distress. Sixth, the person engages in behaviours aimed at distraction or escape from the psychological

distress with little or no thoughts on the long-term consequences of the behaviours (Baumeister, 1990). According to Baumeister (1990), the six stages of the escape theory must occur in a causal order as one step leads to another. For example, if the person blames their shortfall on the environment rather than on themselves (step 2), then the escaping behaviours (step 6) will not occur.

With reference to the escape theory (Baumeister, 1990), the participants in this study may have experienced a similar process as outlined by the six stages of the escape theory. First, the participants experienced distressing events such as bullying, alienation and criticism. Second, the participants felt inadequate and blamed themselves for such experiences. Third, the participants realized that this inadequacy portrays them as unattractive as men. Forth, the realization of being unattractive led to the experience of psychological distress amongst the participants. Fifth, the participants sought to escape such psychological distress. Sixth, the participants engaged in muscle building behaviours (e.g., weight training) to escape their psychological distresses.

Baumeister (1988) applied the escape theory to sexual masochism and found that emotionally or physically abused individuals may engage in masochistic behaviours to escape the psychological distress caused by their self-perception. It was suggested that the focus on the intense and painful bodily sensations in masochistic behaviours offered a temporary escape from a high level of self-awareness (Baumeister, 1988). A similar experience was reported in the present study by a participant who described his engagement with the painful and intense bodily sensation of weight training as a temporary escape from psychological distress. Nevertheless, Vartanian (2012) suggested that muscle-building behaviours used as an escape from the emotional impact of self-discrepancy can exacerbate the

perceived discrepancy rather than reduce it. In line with this, the present study found that the participants continued to experience discrepancies despite the temporary escape they experienced.

The men in this study also talked about their journey towards recovery from MD. The concept of recovery has been discussed in the mental health literature mostly in relation to recovery from addiction (see White, 2007). Part of participants' experiences in the present study mirrors the experiences of individuals with addictions. Firstly, the participants talked about continuing their lifestyle of over-eating, extreme exercise routines and steroid abuse despite the presence of physical health concerns. This is consistent with Garland (2012)'s suggestion that addicts experience an urge to continue with their behaviours despite experiencing physical or psychological consequences. For example, problem gamblers continue gambling despite the mental and financial consequences (Rogier et al., 2020). Secondly, the participants experienced a low point in their lives during which they experienced existential crisis and depression. This low point, referred to as rock bottom, was a turning point in the participants' journey towards recovery. This finding is consistent with previous studies on addiction that suggested individuals with addictive behaviours experience a rock bottom period that prompts them to reevaluate the meanings they ascribe to their experiences. (Gray, 2005; Kassai et al., 2018).

The experience of rock bottom is also commonly used in the addiction literature to refer to a turning point (Prins, 1994), existential crisis (McKeganey, 2001) or a nadir-moment in Maslow's words (Bevacqua & Hoffman, 2010). Maslow (1987) describes a nadir experience as a dramatic change from the individual's everyday experiences. The nadir experience represents the individual's lowest point in their life and includes feelings of emptiness, powerlessness and depression (Kumar, 2005). In describing

'rock bottom' as an event, Kemp (2001) describes this as the moment in which the individual realizes that control or at least the illusion of it is lost. Thirdly, During recovery from MD, participants experienced new perspectives that allowed them to live a life without the dysfunctional preoccupation with muscularity. This finding is consistent with Sibley et al. (2020)'s description of recovery from addiction. Sibley et al. (2020) described recovery from addiction as a process of learning to live life without the behaviours or the substances.

Although the experience of rock bottom in the present study prompted two participants to seek professional help for mental health, it is essential to note that they did not seek help for MD as they were unaware of the condition. This finding supports previous studies that suggested men do not seek treatments for MD (see pope et al., 2000; Leone et al., 2005). One participant discussed his health issues with a friend and sought professional help as a result of his friend's encouragement. This finding supports Leone et al.'s (2005) suggestion that encouraging conversations and discussions by close friends around body image prompts individuals with MD to seek treatment.

Dawes and Mankin (2004) found that in comparison with AN, in which individuals are often forced into treatment due to the rapid decline of physical health and appearance, individuals with MD are often perceived to be healthy, and therefore, many underlying health issues remain untreated. The present findings suggest that although men who experience MD may not be forced into treatment due to physical health, they may be forced to seek treatment due to the decline of mental health.

Participants were offered medication and therapy as treatment options; however, they only discussed therapy's life-changing role during their recovery from MD.

During therapy, participants gained new perspectives and insights into the condition of MD. These new perspectives allowed the participants to evaluate the meanings ascribed to their muscle size and the values they assigned to having large muscles. Therefore, therapy helped the participants in two ways: firstly, it reduced the emotional impact of perceiving themselves as less muscular, which is evident by one participant's new perspective that he can be happy without having large muscles. Secondly, therapy helped reduce the value the participants assigned to having large muscles, which is evident in another participant's experience of realizing that the importance of muscle size was mostly his perception, and nobody cared if he was thin. These findings support Vartanian's (2012) suggestion that therapy should first aim to reduce the emotional impact of an individual's self-discrepancy and then aim to reduce the importance they assign to their ideal self-guide.

Conclusion

This study set out to explore men's lived experiences of MD. Three men who self-identified to have experienced and recovered from MD shared a common narrative of their childhood struggles, pursuit of an unrealistic muscular body, and journey towards recovery. The participants discussed their struggles with their self-esteem and masculinity due to childhood experiences of bullying, isolation and family issues. The participants pursued an unrealistic muscular body to escape their psychological struggles whilst experiencing a distorted body image. However, this desire for a muscular body combined with a distorted body image gave rise to over-eating, excessive exercise routines and steroid use that resulted in physical and psychological consequences. Although the participants ignored the physical implications of these behaviours, the psychological repercussions compelled them to seek treatment. Lastly, the participants experienced a change of perspective during

therapy sessions. This change of perspective helped the participants to experience life without the excessive preoccupation with muscularity.

The present findings support the link between childhood experiences and MD whilst emphasising the role of masculinity in men's experiences of MD. Furthermore, the present study shed light on behaviours serving as a coping strategy with psychological distresses, which were consistent with the escape theory. Moreover, parts of men's experiences and recovery from MD was found to be consistent with addiction literature. Additionally, the present study emphasised the vital role of therapy as a treatment option whilst highlighting men's lack of help-seeking for MD. Such findings highlight the importance of giving men a voice in understanding their experiences of body image disturbances.

Limitations and future recommendations

Despite the findings, this study has certain limitations. This study set out to use the IPA approach for its focus on the lived experiences of individuals. However, it is essential to consider IPA's limitations. One limitation of IPA is that it does not offer causal explanations for the participants' experiences. Although the present study aimed to explore the participants' lived experiences and the meaning-making process, researchers and practitioners may be interested in understanding the underlying reasons for participants' experiences and the conditions that give rise to such experiences rather than just understanding the experiences (Willing, 2008). Nevertheless, the strength of the present study lies in its contribution in filling the gap left by quantitative research methods by giving men a voice and by providing a rich picture of understanding men's experiences of MD.

The purposive sample recruited from a group of men who self-identified to experience MD was consistent with the small homogeneous sample recommended

for an IPA study (Smith et al., 2009). However, it is not a widely representative sample of men. Future studies could explore men's experiences of MD with different ethnicities and locations globally to better understand the cultural influences on the experiences of MD. Eatough and Smith (2008) suggest that recognising similarities and differences in the experiences of MD allows for a change of focus from the specific to a general perspective. Although MD is primarily experienced by men (Pope et al., 2000), research suggests that women can also experience MD, particularly female bodybuilders (see Hale et al., 2013). Future studies could explore females' experiences of MD and how their experiences may differ from men's experiences.

As noted earlier, the participants self-volunteered to take part in the current study in responding to a social media post. It is possible that a portion of men with MD who could have contributed valuable insights to the study did not volunteer. Furthermore, I found participant recruitment difficult due to a lack of support groups related to muscle dysmorphia (MD). I was able to find a few Facebook groups, two of which seemed inactive. Previous studies have recruited participants from bodybuilding communities and needle exchange services, where steroid users attend to receive needles and syringes. As previously discussed, recruiting participants from these settings carries other limitations. For instance, not every bodybuilder suffers from MD and not every steroid user would want to share their experience of steroid use due to the stigma attached to steroid use. Creating more support groups (via online platforms and in the community) for individuals who may experience MD could lead to better recruitment of participants for future studies.

It must be mentioned that the men in this study talked about their experiences through their memory. Although men in this study may have forgotten crucial details,

this allowed the participants to reflect on their journey and disclose what has worked for them in their recovery from MD. Moreover, the use of single interviews with each participant could be a limitation. Future studies could use multiple interviews with each participant over a time period to explore the participants' experiences in a longitudinal approach.

This study used the Biographical narrative approach (BNIM) as an interview guide. Although the BNIM method offers the participants a voice and the freedom to tell their stories in their own way, it may not lead to specific details that we want to know. Despite these limitations, the findings of the present study offer practical and educational implications that are discussed below.

Implications

Although the present study aimed to understand the lived experiences of MD and not causal explanations, the findings highlight the influence of childhood bullying, social isolation and dysfunctional relationship with the father on the development of MD. The present findings also emphasise the role of these early experiences in men's low self-esteem and struggle with masculine identity, which can manifest as body dissatisfaction and an excessive preoccupation with muscularity. Education to parents and institutions where children interact may be helpful in the intervention and prevention of such experiences.

Most studies around body image have been concerned with women and how the ideal thin body relates to women's self-worth and femininity (see Grogan, 2016; Smolak et al., 2001; Hargreaves & Tiggemann, 2006). The present study highlights the important relationship between self-esteem and masculinity in men's experience of MD. These findings should encourage psychological practitioners (e.g., therapists) to develop a more gendered approach when working with men. These approaches

can aim to produce male-specific measuring and diagnostic tools based on men's experiences of MD rather than previous diagnostic tools that were more specific to women's body image disturbances.

The present findings suggest that men may experience physical distress (e.g., digestion issues) and psychological distress (i.e., depression) prior to seeking treatment. Such findings highlight the importance of MD awareness in psychological and general practices when working with men who may be experiencing MD. By being aware of distresses and behaviours related to MD, practitioners can aim to treat the condition by offering appropriate treatments such as therapy rather than treating the symptoms (e.g., digestion issues) alone. If practitioners suspect that MD is present in an individual, they may ask about the individuals eating and exercise routines, body satisfaction and potential steroid use. Furthermore, health care practitioners and research funders have found it difficult to appreciate the devastating consequences of MD when behaviours associated with it involve diet and exercise (Tod et al., 2016). Diet and exercise are often valued as traits of self-discipline and motivation (Griffiths et al, 2015). The present findings highlight the seriousness of MD as a condition that can have devastating consequences on men's physical and mental health despite the appearance of positive traits.

CRITICAL REVIEW

Yardley (2000) proposes four criteria for evaluating the quality of qualitative research. These include sensitivity to context, commitment and rigour, transparency and coherence, impact and importance. This section discusses the validity and quality of the present study in line with Yardley's (2000) broad guidelines.

Sensitivity to context

Yardley (2000) suggests that a good qualitative study will display sensitivity to context. I have attempted to show sensitivity to the context from the very first stage of the study. The very choice of doing IPA as an approach to explore the lived experiences of the participants and my rationale for undertaking IPA demonstrates my focus on the context of the particular. IPA is sensitive to the context from the outset as it recruits purposive samples of individuals who share a common experience.

My sensitivity to context is evident in my discussion of the existing literature on MD and the gaps in the literature. Furthermore, I discussed IPA's theoretical underpinnings in detail and provided details about the participants' demographics and the support groups from which the participants were recruited.

I demonstrated sensitivity to context through my interactions with the participants. During the data collection, I tried to put participants at ease by having brief informal conversations and showed empathy by sharing parts of my own experiences of MD. Furthermore, I was aware of the potential power imbalance that may arise if the participants perceived me to be an expert. To address this, I informed the participants that they were experts by experience, which was the reason for their recruitment. During the analysis, I attempted to give the participants a voice and support my interpretations by providing verbatim extracts. According to Smith et al. (2009), a researcher who navigates through these stages, conducts good interviews and offers plausible interpretations has successfully demonstrated sensitivity to context.

Commitment

Yardley (2000) describes commitment as a considerable engagement with the topic (whether as a researcher or a fellow sufferer), extensive engagement in the relevant theoretical or empirical data and the development of skills in the methods utilized. My engagement with the topic began when I realized that I had experienced a condition termed Muscle dysmorphia for many years. I also realized that there is a general lack of awareness about the topic. These realizations prompted me to want to explore other men's experiences of MD. My initial search revealed a scarcity of studies, particularly qualitative studies, on the topic (Tod et al., 2016). Therefore, I felt that research exploring how men experienced and recovered from MD would contribute to the knowledge of the topic.

Although I was a novice researcher using IPA for the first time, I have demonstrated my commitment to the approach by engaging in extensive readings about the method and discussing the approach with experienced supervisors. However, I found the experience of being immersed in the high volume of collected data overwhelming at times. To reduce feeling overwhelmed, I found that taking breaks and coming back to the data with a fresher mind helped immensely in the analysis.

Rigour

Yardley (2000) describes rigour as the completeness of data collection and analysis. To demonstrate this, the researcher must demonstrate that the sample provided appropriate information relevant to the topic of the study, the interviews were of high-quality standards and the analysis were carried out thoroughly. To ensure this, I carefully selected a homogenous sample that matched the research question and conducted interviews according to the training I received during my

supervision meetings. I analysed the data in line with Smith et al.'s (2009) guidelines which offered a thorough and systematic method of analysis that is sufficiently idiographic and interpretive. Furthermore, Smith et al. (2009) suggest that rigour is also demonstrated by how well the themes are prevalent across the sample. In the present study, the prevalence of themes ranged from 2/3 to 3/3, indicating sufficient prevalence.

Transparency

According to Yardley (2000), transparency refers to the clarity the researcher provides for the stages of the research process. To achieve clarity, I have described how the participants were recruited, how the interview was conducted and included tables that provide details about the participants. I have also provided a reflexivity statement outlining my position and experiences in relation to the research. Moreover, I have described every stage of the analysis and included samples of the analysis in the appendices.

Coherence

Yardley (2000) describes coherence as the consistency between the study and the theoretical assumptions of the implemented approach. Smith et al. (2009) suggest that the coherence of a study is mainly judged by reading the finished write-up. Therefore, if a study claims to be IPA, then the write up must reflect the phenomenological and interpretive focus of the approach. To ensure that the present study demonstrates coherence, I have carefully read the drafts, redrafted them throughout the research process and put myself in the reader's position by asking questions such as does the study present a coherent argument?

Impact

Yardley (2000) points out that however sensitive, coherent and plausible a study is, the real test of its validity is its impact and utility. The impact and utility of the study is judged by whether it has something novel, important or useful to tell the reader (Yardley, 2000). This is a fundamental part of the IPA approach, and that researchers utilizing IPA aspire to make novel and valuable contributions to the literature (Smith et al., 2009). The present study offers novel and valuable insights into understanding men's lived experiences of MD, which is an under-researched topic.

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APPENDICES

Appendix A: interview schedule

Appendix B: extract from reflexive diary

Appendix C: recruitment post

Appendix D: ethical approval email

Appendix E: participant information sheet

Appendix F: consent form

Appendix G: debrief form

Appendix H: initial noting of matt's transcript

Appendix I: developing emergent themes for Matt

Appendix J: searching for connections across the themes

Appendix K: emergent patterns across the cases

APPENDIX A: INTERVIEW SCHEDULE

Session 1

Single question aimed at inducing narrative (SQUIN):

As you know I am conducting a study on men's experiences of muscle dysmorphia and their recovery. I would like you to tell me your life story, all the events and experiences that were important to you. Start wherever you want. Please take the time you need. I will listen first, I won't interrupt. I will just take some notes for afterwards.

Purpose of the question: To elicit a narrative in which the participant controls the beginning, end, timing and structure of the narrative

Session 2: follow up from SQUIN

Purpose of questioning in session 2: To obtain more in-depth data.

Examples of follow up questions during session 2:

"You said....do you remember any more about that particular... occasion*, how it all happened?"

OR

"You said... Do you have any thoughts?

(or feelings) about that time?

APPENDIX B: EXTRACT FROM REFLEXIVE DIARY

Initial impressions and interview with Matt

Mat was my third participant and the youngest of the three. First things I noticed about matt is that he actually looks young, most bodybuilders look much older than they really are, but matt looked like the typical young lad that you would expect to see at the pub on Saturdays laughing and acting drunk with his friends. but here is the second thing I noticed about matt, he looked very introvert. In his Facebook pictures he was always wearing baggy hoodies with his hood up, as if trying to protect his body. I found myself questioning are these men really recovered? Yes, they stop the extreme gym going, extreme diet and steroids but they still carry around with them behaviours that are associated with men who suffer from MD. Before we started the interview matt came across quite nervous, he would make nervous jokes and nervously laugh as if silence made him uncomfortable. I also noticed that it was very important for him how he looked on camera, so he was constantly adjusting himself and looking for that perfect angle. During the interview, from Matt's tone of voice I could pick up regret at times, especially when he was talking about his extreme exercise routines. It felt like as if he regrets wasting many years of his life being preoccupied with his body. He sounded sad at times and at times he was excited. When the interview ended, I sensed that Matt was happy or uplifted compared to the start of the interview. Perhaps this was because he felt like his experiences were a burden to him and talking about them made him feel better. I tried to make him as comfortable as possible by sharing a bit of my own experience with MD. I noticed then he became much more comfortable and relaxed.

APPENDIX C: RECRUITMENT POST

Public message sent to social media groups (muscle dysmorphia/body dysmorphia support group) to recruit participants

Hi, I am carrying out a research on muscle dysmorphia as part of my master's dissertation at the university of Huddersfield. For my study I am looking for

- Men who are 18 years or older
- Have experienced muscle dysmorphia
- Have recovered.

If you would like to take part in a one-to-one interview over an audio or video call (depending on your preference) which may last from one hour to two hours and match the criteria mentioned above, then please privately message me. The interview involves two sessions. In the first session you will be asked to narrate your life story and experiences. During the second session you will be asked further questions about the topics you have talked about.

Your details and information will remain confidential and your name will be replaced with a pseudonym to keep you anonymous. You can also skip any question or withdraw from the study at any point before, during and until two weeks after the interview.

The data collected from you will be analysed for my dissertation. If you have any other questions, please do not hesitate to ask me via private message.

Many thanks

APPENDIX D: ETHICAL APPROVAL EMAIL

SHAYEGANI - SREIC PGR Panel Application - SREIC/2021/025 - Final Outcome



SHUM Research Ethics

Thu 25/03/2021 14:15



To: Arash Shayegani (Researcher)

Cc: Santokh Gill; Timothy Gomersall; Matthew Haines; Robert Naughton

Dear Arash,

The Panel Reviewers have confirmed that you have addressed the issues raised to their satisfaction and your ethics application has now been **approved outright**.

This approval is subject to the content of the application in its current form. If your research changes, from that in the application, it is incumbent on you as the researcher to update and seek further approval from SREIC. Without a re-approval your research is not supported by the University.

With best wishes for the success of your research project.

Regards,

Kirsty

(on behalf of the School Research Ethics and Integrity Committee (SREIC))

School Research & Enterprise Office✉: hhs_srep@hud.ac.uk🌐: www.hud.ac.uk

School of Human and Health Sciences R&E Office – R1/17
University of Huddersfield | Queensgate | Huddersfield | HD1 3DH

APPENDIX E: PARTICIPANT INFORMATION SHEET

Exploring men's experience of muscle dysmorphia in the UK

We would like to invite you to take part in our research study. Before you decide, we would like you to understand why the research is being done and what it would involve for you. If you have any questions about the information provided, please contact Arash shayegani at arash.shayegani@hud.ac.uk, or the main project supervisor Timothy Gomersall at T.gomersall@hud.ac.uk

What is the purpose of this study?

The aim of this study is to gain a deeper understanding of how men experience muscle dysmorphia. Understanding the lived experience of men who have experienced muscle dysmorphia could lead to better prevention strategies and treatments.

Can I take part?

You can take part in the study if you are a male over 18 years old who self-identifies to have experienced muscle dysmorphia.

What will the study involve?

You will be asked to take part in a one to one interview which could last 1 to 3 hours.

Are there any risks or benefits of taking part?

Your participation will lead to a better understanding of men's experience of muscle dysmorphia; However, you may experience distress during the interview in which case you will be able to withdraw at any time and stop the interview.

Do I have to take part and will my involvement with the study be kept confidential?

You have the right to withdraw from the study at any time during and after the interview until the analysis begins by the end of March 2020. For confidentiality purposes you will be allocated a number before the interview. You will be asked to provide that number if you decide to withdraw your data. All information collected from you during this study will be kept secure and any identifying material, such as names will be removed and replaced with a number in order to ensure anonymity. Only the researcher and the project supervisors will have access to your data

What will happen to the results of the research study?

The result of this study will be included as part of my master's thesis. There is a possibility that this research will be published in an academic journal. In the case of publication, your name will be replaced with a pseudonym to maintain confidentiality.

APPENDIX F: CONSENT FORM

Exploring men's experience of Muscle dysmorphia in the UK

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions using the researcher contact details.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that should I wish to withdraw then I would need to contact Arash Shayegani by sending an email to arash.shayegani@hud.ac.uk before 31st of march 2021.
3. I understand that data collected in the study may be looked at by the research group. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.
4. I agree to take part in the above study.

Yes, I agree with the above statements and am happy to take part in this study.

No, I do not wish to participate.

APPENDIX G: DEBRIEF FORM

Exploring men's experience of muscle dysmorphia in the UK

Thank you for taking part in our research study.

If you have any questions or concerns, please contact Arash Shayegani at arash.shayegani@hud.ac.uk, or the project supervisor Timothy Gomersall at T.gomersall@hud.ac.uk

What was the purpose of this study?

The aim of this study was to gain a deeper understanding of how men experience muscle dysmorphia.

What now?

The results will be analysed and written up for my dissertation. If you have any concerns or have experienced distress during your participation, you can find below contacts for support organisation that are able to offer guidance and support.

Men's Health Forum

24/7 stress support for men by text, chat and email.

Website: www.menshealthforum.org.uk

Samaritans

Confidential support for people experiencing feelings of distress or despair.

Phone: 116 123 (free 24-hour helpline)

Website: www.samaritans.org.uk

Mind

Promotes the views and needs of people with mental health problems.

Phone: 0300 123 3393 (Monday to Friday, 9am to 6pm)

Website: www.mind.org.uk

Body Dysmorphic Disorder Helpline

0845 390 6232

Data protection

All information collected from you during this study will be kept secure and any identifying material, such as names will be removed and replaced with a number in order to ensure anonymity and it would only be myself and my supervisor who have access to the data. Please keep hold of the identification number which will be given to you by the end of the interview. Should you wish to withdraw from this study, you would need to email myself at u1576428@unimail.hud.ac.uk before the end of January 2020 and provide your identification number.

APPENDIX H: INITIAL NOTING OF MATT'S TRANSCRIPT

3

1 Matt's transcript

2

3 Trauma

4 I remember when I was young, I was very skinny.

5 I used to get bullied for it at school and even the

6 kids around my neighbourhood. They had a name

7 for me 'the electrical skeleton'. Even my uncles

8 and family members called me that. It used to get

9 to me, you know, and the funny thing is that when

10 they found out that it gets to me, they called me

11 that every time they were pissed off with me.

12 think over time, this will create an issue in your

13 head, and you just start hating yourself for it

14 (Matt, 1-6)

15

16 Then I remember wanting to join a self defense

17 class, so I heard there was a boxing and a kongfu

18 club nearby. So I convinced my mom to take me

19 there and sign me up. She gave me money she said

20 go and sign up. So I went to go to this Kungfu

21 class and I remember when I entered the club I had

22 to walk through a gym to go to the other side of

23 the club where the kunfu classes were taking

24 place.

25

26 I remember the feeling I had when I stood there

27 looking around me. I wanted to forget about the

28 Kungfu and join the weight training. So I went over

29 to the guy at the desk and I said can I join this

30 gym? He said no you are too young. Yes I was

31 about 12 at the time. So I just went over to the

32 Kungfu club hoping to get big and strong or some

33 skills that will give the confidence I was lacking.

34 So after attending the Kungfu club for a few

35 months I remember I started eating better and just

36 kept on looking at my body in the mirror looking

37 for improvements. I did feel strong, I felt better

38 about myself.

39

40 By the time I turned 14 I met a new friend at this

41 new school. He told me he goes to a gym that is

42 not much far away from my house. He asked if I

43 wanted to go to the gym with him so I said yes. So

44 I walk in to this gym for the first time since I was

45 12 and at the desk they guy asks me how old I

46 was? I panicked I thought they would say im too

47 young again! So without much thoughts I said 16!

48 Two years older than I really was. Then he said

49 good coz you must be 16 years or older to join the

50 gym.

Young and skinny is what matt remembers about his youth

why electrical skeleton? using the label as a weapon?

Matt changes the use of pronoun from first person to second person

why hate the self?

Self - defense a core of vulnerability?

why would he have to convince his mom?

instant fascination with the gym?

Why such a desire at this age?

big and strong to increase confidence?

Start of mirror check?

Encouragement to go to the gym by a friend

Panic in fear of not being able to join the gym?

Trying to get in the gym

1

APPENDIX I: DEVELOPING EMERGENT THEMES FOR MATT

Trauma (3.1)

Body-shamed (3.4)

Degrading label (3.5)

Self-blame (3.12)

Vulnerability (3.16)

Idealised masculinity (3.20)

Fascination with muscles (3.26)

Fascination at young age (3.29)

Size and strength for confidence (3.33)

Changing of eating habits (3.36)

The mirror as a measurer of body progress (3.39)

The whimpy kid (3.32)

The tough guy (3.33)

Picture taking (3.45)

New friend and gym (3.40)

Anxiety and panic (3.45)

Lied to go gym (3.47)

Obsession with muscular action figures (3.50)

Chinese whispers (3.52)

Cult of bodybuilding (3.53)

Appearance anxiety (3.55)

Appearance obsession (3.56)

Social comparison (3.58)

Ritualistic behaviours aimed at easing anxiety (3.61)

Questioning one's sanity over irrational behaviours (3.62)

The body as a means to escape (3.64)

The body as an investment (3.67)

Identity (3.68)

Gym expert (3.69)

The body as a temple (3.71)

The body as a prison (3.73)

Filling the inner void (3.76)

Self-imposed prison (3.77)

Body as a coping method (3.80)

Personal standard of what a man is (3.11)

Getting bigger to compensate insecurity (3.30)

Fantasy of proving other wrong (3.36)

Harmful massages of bodybuilders (3.64) (3.79)

Bodybuilder's exploitation (3.87)

The critical self (3.100)

The questioning self (3.102)

Resorting to selling steroids to self-fund (3.128)

The addictive feelings of validation and attention (3.134)

Psychological addiction to steroids (3.141)

Lack of erection as a dig at masculinity (3.143)

The façade of the bodybuilding identity (3.156)

Passion or obsession (3.158)

Body as a distraction (3.160)

Singles out his father (3.162)

Muscle building as an accomplishment (3.164)

Picture taking (3.168)

Distorted body (3. 169)

Never ending cycle (3.170)

Limits of the body (3.171)

Socially awkward (3.173)

Physical flaw (3.175)

Grudge (3.178)

Masculine traits (3.180)

“war” as a symbol of masculinity (3.184)

Still unhappy even after noticeable change (3.186)

Steroid as the answer (3.190)

Never ending cycle (3.193)

Limits of the body (3.195)

Psychological pain of being small (3.201)

Social learning on social media (3. 203)

Rock bottom (3.205)

Underestimating the psychological consequence of steroids (3.208)

The BDD loop (3.209)

Everybody has their own genetic limits (3.210)

Diet paranoia (3.213)

Questioning the purpose of life (3.217)

Fruits of my labour (3.220)

Isolation as the result of low self steem and confidence (3.221)

Steroid guidance through friend (3.225)

Steroids as a short cut (3.226)

Temporary transition of body distortion (3.228)

Seeking control and approval under the bodybuilding mask (3.229)

Body as means to gain respect (3.231)

The mirage of ideal body (3.233)

Rationalizing MD symptoms (3.234)

Deep denial (3.236)

The façade of social media (3.238)

Afraid of the reality of the mirage (3.240)

Existential crisis (3.243)

Depressed self (3.244)

Body shutting down (3.245)

Hitting rock bottom (3.246)

Emergency department (3.247)

Doctor as the last resort (3.252)

Men don't talk (3.253)

Lack of awareness about MD (3.255)

The bigger picture (3.257)

Life after MD (3.260)

Body as a means of seeking approval (3.261)

Life after MD (3.262)

Acceptance, not attention (3. 263)

The slippery slope (3.264)

Body anxiety (3.265)

Lack of social awareness (3. 266)

Therapy (3.268)

Perspective (3.269)

Steroids, the hidden suffering (3.270)

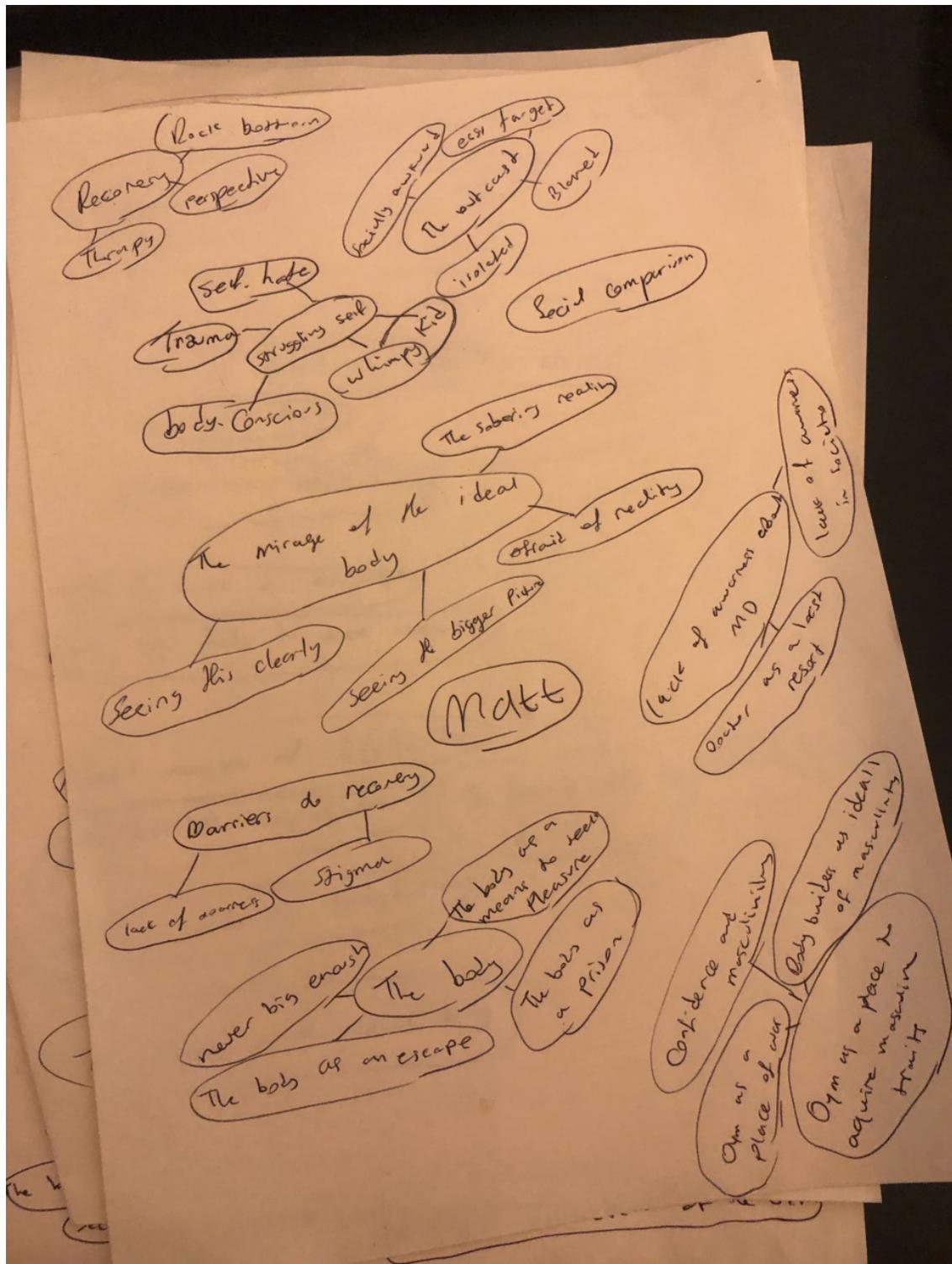
Self-acceptance (3.275)

Self-healing (3.277)

Awareness leads to help seeking (3.280)

Seeing things clearly (the mirage) (3.285)

APPENDIX J: SEARCHING FOR CONNECTIONS ACCROSS THE THEMES



APPENDIX K: EMERGENT PATTERNS ACROSS THE CASES

