NARRATIVE WORKS
Issues, Investigations, & Interventions

Thickening Thin Narratives: A Feminist Narrative Conceptualization of Male Anorexia Nervosa

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The purpose of this article is to conceptualize a feminist narrative approach to male anorexia nervosa (MAN). Both narrative and feminist theories have been utilized to enrich the discourse of AN among women. An unintended result of this primary focus on women's experiences has been a limited focus on the experiences of men with AN. This article will explore a contemporary social discourse on masculinity, why some men utilize AN as a means of attaining the ideals put forth through such discourse, and how a feminist narrative approach can be applied to working with men struggling with AN.

Anorexia nervosa (AN) is an issue that primarily affects women. This situation is reflected in the high prevalence of reported cases of AN among women and the strong focus on women in the academic literature. Considering that the vast majority of reported cases of AN are among women, it is expected that much attention be given to considering why women develop AN and what their experiences are. Narrative and feminist approaches have been particularly effective in eloquently describing the phenomenon of AN among women in Western society (e.g., Bordo, 1993; Brown, 2007a; Brown, Weber, & Ali, 2008; Malson, 1997). An unintended result of such a strong focus on women has been that AN among men has been almost completely ignored in the academic literature. The result has been a narrow conception of male AN (MAN), especially regarding why it is that some men develop AN. Many of the insights that have emerged from feminist and narrative approaches that have thickened the academic discourse on AN among women can be effectively used to further conceptualize MAN. The purpose of this paper will be to formulate a feminist narrative approach to MAN.

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This paper will begin by discussing the low rate of reported cases of MAN, including factors that contribute to such rates. The next section will review the academic literature on both MAN and masculinity. The themes most commonly found in the literature will be the focus in developing a feminist narrative approach to MAN. This section will then present a conceptualization of why men develop AN and the meaning inherent in their struggles. The following section will present certain feminist and narrative techniques deemed most applicable in addressing MAN. These techniques will be applied to the case study of a young man with AN, Jackson, to illustrate the potential for a feminist narrative approach to address MAN.

Women overwhelmingly comprise approximately 90-95% of reported cases of AN (Crosscope-Happel, Hutchins, Getz, & Hayes, 2000), with men make up the remaining 5-10% reported (McVittie, Cavers, & Hepworth, 2005). The exact rates of AN among both men and women are unknown since not all cases are reported for either gender. It is possible that cases of MAN are more likely to go unreported due to men's perceiving AN as a female issue. Andersen, Cohn, & Holbrook (2000) speculate that males may actually make up about 25-30% of those struggling with AN. However, little corroborating evidence has been found to support this estimation. Due to much of the attention in the academic literature being focused on AN in women, relatively little research has focused on MAN. This is reflected in the way that AN has been presented through the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

The DSM-IV is itself a master narrative that significantly influences how AN is conceptualized and how this, in turn, affects MAN. A master narrative is a "technique of power" (White & Epston, 1990, p. 23). Drawing from the writing of Foucault (1980), White and Epston (1990) state that such techniques are used to organize people into separate groups differentiated by well-defined group identities (see also Madigan, 1998). These groupings make for greater efficiency in managing and evaluating peoples' behaviors. As people internalize these dominant stories around who they are to be, they begin to engage in self-monitoring and regulating their own behavior (White & Epston, 1990). The DSM-IV serves as a document that supports a biomedical master narrative of *mental disorders*, defining such *disorders* through specific diagnostic criteria, cognitive, and behavioural norms (Sanders, 2007), and framing them as individual pathologies primarily based in a person's genes (Jasper, 2007; Wylie, 2004).

Such a biomedical view has raised particular concerns in addressing AN in general and MAN in particular. By framing AN as individual pathology, little attention is given to the social and political factors—for instance, gender roles/expectations, socioeconomic status, societal pressures around thinness—both of which are overlooked (Jasper, 2007; Sanders, 2007). Another issue is that the DSM-IV makes a false differentiation between who is deemed "anorexic" and who is "normal" (Brown, 2007b). According to Brown (2007b), the DSM's diagnostic criteria serve as a dividing line. On one side of the line are those who have a *healthy* preoccupation with thinness, and on the other side are those who have a *pathological obsession* with thinness necessitating treatment. While Brown (2007b) presents this dichotomy as imposing a division between "normal" and "anorexic" women, the DSM-IV's diagnostic criteria for AN has also proven effective in maintaining the view of AN as primarily a woman's issue.

The DSM-IV (American Psychiatric Association, 2000) states that AN is diagnosable when the following criteria are met: the person in question refuses to maintain a minimally normal body weight for his or her height and age; displays an intense fear of becoming fat despite being underweight; has a distorted view of his or her own body; and, in a postmenarcheal female, is experiencing amenorrhea. It should be noted that this criteria may exacerbate low rates of reported cases of MAN in that it portrays AN as a female issue to practitioners. This portrayal is seen in the fourth criterion for diagnosis provided in the DSM-IV (American Psychiatric Association, 2000), the loss of menses in postmenarcheal females. Including this as part of the formal criteria conveys an assumption that AN is an issue that is only clinically significant among teenage through younger adult women. This does not mean that practitioners would necessarily refuse to diagnose males with AN due to not meeting all four criteria, but it may influence how both practitioners and, in turn, the general public view AN.

It is important to note that the working group assigned with addressing the diagnostic criteria for eating and feeding disorders in the upcoming DSM-V (American Psychiatric Association, 2012) have proposed significant changes from the DSM-IV. For instance, the criterion of loss of menses will be removed with the intent of making the diagnostic criteria more inclusive of men, premenarcheal women, postmenopausal women, and women taking oral contraceptives (American Psychiatric Association, 2012). The working group has also proposed that criterion A of the diagnostic criteria for AN read that

individuals restrict energy intake "leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health" (American Psychiatric Association, 2012). These changes may be a significant step in shifting from a young-woman- dominant paradigm of AN to being an issue that affects both genders and individuals of a variety of ages.

AN's being portrayed as exclusively affecting women influences the rate at which men are diagnosed and how willing men are to seek help. Soban (2006) explains:

> Since everyday understanding of anorexia nervosa strongly associates the disorder with femininity, it has been difficult for men who suffer from the disorder to come forward out of fear they will not be taken seriously or that they will be thought of as 'less masculine' by social standards. (p. 252)

Men seeking help for AN may be concerned about not having their struggles recognized or being seen as less of a man for having a feminized problem (Pope, Phillips, & Olivardia, 2000). Some research has indicated that health professionals are more likely to view men who present with AN as being more "feminine and as having atypical masculine identities" (McVittie, Cavers, & Hepworth, 2005, p. 414). Reporting a concern that may be perceived as feminine in nature may make seeking help much less desirable, resulting in considerably fewer reported cases of MAN, skewing researchers' and practitioners' ability to accurately gauge the prevalence of MAN and how it compares in its presentation to AN among women. Given the low rates of and limited focus on MAN, it is helpful to consider what the academic literature suggests about MAN.

Even though the literature on MAN is relatively limited, there are several insights provided in the discussion. Some authors state that males with AN tend to present in similar ways as females do in the areas of "clinical characteristics, psychiatric comorbidity, and psychosocial morbidity" (Gila, Castro, Cesena, & Toro, 2005, p. 222; see also Carlat, Camargo, & Herzog, 1997). Conversely, others state that men with AN display higher rates of co-existing psychiatric issues than do women, especially in regard to addictions, mood disorders, antisocial personality traits, and suicidality (Andersen, 1999a; Bramon-Bosch, Troop, & Treasure, 2000). Bramon-Bosch et al. (2000) suggest that these higher rates of co-existing issues may be influenced by the likelihood that men

are more likely to seek help for co-existing issues, such as depression or an addiction, rather than simply AN.

Multiple factors have been suggested as contributing to MAN. Andersen (1999a) offers four primary predisposing factors: first, males with AN are more likely to have a history of childhood obesity as compared to females with AN (see also Andersen, 1999b; Andersen & Holman, 1997); second, men may lose weight to improve athletic performance; third, men may feel the need to lose weight to avoid unwanted health issues; and, fourth, gay men might lose weight as a means of improving a relationship with a partner (see also Jones & Morgan, 2010). Rates of AN are especially high within gay communities (Crisp et al., 2006). This might be due to an increased focus on thinness in gay culture (Andersen, 1999a; Andersen, 1999c; Carlat et al., 1997; Jones & Morgan, 2010). As men feel pressure to comply with contextual expectations to be thin, their body image and, in turn, their overall self-image may be affected (Yager, 2000). Note that these factors transcend an intense desire to avoid becoming "fat" (American Psychiatric Association, 2000)—they speak to situations in which men are introduced to the idea of trying to attain authority over their lives through exerting stringent control over their bodies. Each of these factors links the physical condition of the male body with a sense of personal control and acceptability within their social context.

MAN has been closely associated with certain professions and sports. For instance, there are high rates of AN reported among jockeys, wrestlers, dancers, swimmers, and models (Bordo, 1993; Comer, 2005; Gillett & White, 1992; Mickalide, 1990). The common thread among these professions is a culture of thinness and subjection of the body to rigid physical demands. This theme has been used to describe MAN narrowly as simply being the product of involvement in professions that demand strict weight maintenance (Bordo, 1993). The result is a reductionistic view of MAN as an occupational hazard, as men succumb to profession-related pressures to be thin. This view does not account for the experiences of men not involved in such professions and, more significantly, does not address the deeper meaning that men are conveying, albeit indirectly and unintentionally, through AN. The deeper meaning men may be trying to communicate through AN will be discussed below.

The literature on MAN is intertwined with the literature on masculinity, which addresses who men are supposed to be and what they are to look like. As has been the case for women in the past several

decades, there has been a recent increase in societal pressures for men to conform to socially-prescribed ideal body types. Bordo (1999) states that "beauty has (re)discovered the male body" (p. 168), meaning that men are increasingly subjected to social discourse prescribing what they should look like (Soban, 2006). Although it has been stated that men experience less body dissatisfaction than women (Gila et al., 2005), this does not diminish the presence of body dissatisfaction among men (Crosscope-Happel et al., 2000; Goldfield, Harper, & Blouin, 1998; Pope, Katz, & Hudson, 1993; Pope, Olivardia, Gruber, & Borowiecki, 1999). It is important to note that men tend to experience body dissatisfaction in different ways than females (Andersen, 1999a; Bulik, 2013; Greenberg & Schoen, 2008). The social discourse on what men are to look like focuses more on *body shaping* than weight loss (Andersen, 1999c; Furnham & Calnan, 1998; Jones & Morgan, 2010). Greenberg and Schoen (2008) state that "the motive for restricting calories may differ across genders. Women may restrict to avoid appearing fat, whereas men may seek defined muscularity" (p. 465). Instead of placing emphasis on a specific weight to attain, men are presented with the image of the ideal male body consisting of lean muscularity (Bulik, 2013; Darcy et al., 2011). This image implies that men, if they are to fit within the confines of the social discourse, are to gain muscle while losing fat. This ideal presentation of the male body perpetuates the idea of men as strong (muscular) and in control (lean). Men's level of satisfaction with their bodies is interlaced with how they feel about and view themselves, and vice versa (Cohane & Pope, 2001). Whether a man feels satisfied with his body affects how he views himself as a man. While recognizing that AN carries deeper meaning than a desire to attain a certain look, the presentation of such an idealized body type contributes to a thin description of masculinity. This thin description emphasizes men's defining themselves through their ability to strictly control their bodies.

As with women, men are defined by how well they reflect socially-prescribed gender expectations. Expectations in Western cultures often define men based on such criteria as socioeconomic status, career success, physical abilities, and intelligence (Ashuk, 2004; Petrie & Rogers, 2001). In other words, men are told that they are to be powerful, successful, and in control of their lives (McCreary, Saucier, & Courtenay, 2005). Such expectations, when internalized, contribute to a culture of masculinity that emphasizes that men are supposed to be strong on all occasions, showing no signs of weakness. Signs of weakness may include showing "negative" emotions, such as sadness, anxiety, and anger, as well

as admitting that one needs help (Greenberg & Schoen, 2008; Soban, 2006). Such perceived weaknesses are to be avoided if possible (Ashuk, 2004). This suppression of "weakness" may play out through the male body. According to Ashuk (2004), "males will tend to learn to suppress their emotional expression, feel shame at the inadequacy of their body regardless of what they actually look like and choose instead to use their body to express their unconscious feelings, albeit aggressive, sexual or other" (p. 31). As the male identity is linked with the male body in specific cultural ways, the values of strength, success, and self-restraint are often projected onto the male physique (Soban, 2006). In essence, the body becomes a safe venue through which to express "negative" emotions. By investing considerable emotional energy into controlling the body, men have a means of expressing their emotions while feeling a sense of power and control.

In formulating a feminist narrative perspective of MAN, many insights can be gleaned from feminist narrative approaches to AN with women. In the early literature on AN, and continuing on in many ways today, conceptualizations of AN tended to pathologize and stereotype women's experiences (Saukko, 2009). As a result, little attention was given to why women struggle with AN (Bordo, 1993). Feminist and narrative writers proceeded to deconstruct the discourse regarding AN, reframing it as more than pathology or a desire to attain a certain look. AN came to be seen as carrying much deeper meaning. Bordo (1993) states:

> The disordered body, like all bodies, is engaged in a process of making meaning… the 'relentless pursuit of thinness' is an attempt to embody certain values, to create a body that will speak for the self in a meaningful and powerful way. (p. 67)

Women use their bodies as a means of communication. Brown (1993a) indicates that the use of the body is a means of women's indirectly communicating that there is something significantly wrong in their lives (see also Brown, Weber, & Ali, 2008). Using the body to communicate becomes a safe means of conveying such messages. Furthermore, "controlling the body becomes one viable way to feel more in control of one's self and one's life" (Brown, 1993a, p. 62). Restriction of the body is a means for men, as well as women, to attain control over one aspect of their lives when other areas may seem out of control. As men correlate their identities with their bodies, their bodies may become a safe mode of conveying significant meaning.

Similar to the competing social discourses encountered by women that promote strict control of their bodies (Brown, 2007a), men face discourses that encourage them to engage in self-regulation. The male body displays the social tensions that pull men in different directions (Toro et al., 2005). Men are told to be strong and successful, to be avid consumers in a commercial society, and to be able to capably meet their goals and desires. This is displayed in the attainment of muscle mass (Greenberg & Schoen, 2008). For men who do not feel strong and successful in other areas of their lives, building muscle mass is a means of attaining a sense of power in their lives. This is juxtaposed with the message that males are told to be in control, keeping their emotions in check, and being able to manage any given situation (Levant, Hall, Williams, & Hasan 2009). This may be physically manifested in the pursuit of leanness and the lowering of one's percentage of body fat (Soban, 2006). In reducing body fat and pursuing lean muscularity, men gain a sense of being in control even though other areas of life may seem out of control. The "anorexic" male body becomes a means of both conveying what men feel they cannot communicate directly—difficult emotions, feelings of not being "masculine"—and gaining a sense of power and control over their lives (Crosscope-Happel et al., 2000). This sense of power and control is something men feel they should, but in actuality do not, possess.

Beyond being a means of indirectly communicating something wrong in one's life, Brown (2007a) states that AN is both an act of compliance and an act of resistance in response to social discourse. This compliance and resistance plays out differently between genders. For men, it is a form of compliance in that they are avidly striving to meet the criteria of masculinity (Soban, 2006). Instead of expressing "negative" emotions that go against the masculine discourse of emotional restriction (Levant, 1992; Levant et al., 2009), men filter their anger, sadness, and frustration into shaping their bodies (Soban, 2006; Rabinor, 2002). In this way, men gain a sense of control by safely managing their emotions without appearing weak (Drummond, 2002). It is a form of resistance in that AN itself represents a break from the expectation of AN as an exclusively female issue (McVittie, Cavers, & Hepworth, 2005; Soban, 2006). Without necessarily realizing it, this break from convention is indicative of the "anorexic" male's dissatisfaction with the gender constraints placed on him.

When these internalized discourses of masculinity do not coincide with men's lived experiences, the result is a feeling of being "stuck"

(Brown, 2003, p. 234). Thinly-described ideals of constant strength, success, and control are difficult to attain. Failure to attain these ideals may result in feelings of failure, ineffectiveness, and emotional isolation (Crosscope-Happel et al., 2000; Kearney-Cooke & Steichen-Asch, 1990). The added challenge in working with men is that men are more likely to view seeking help as an admission of weakness (Greenberg & Schoen, 2008; Soban, 2006); seeking help indicates a lack of mastery over one's lived experience. As discussed above, admission of weakness is akin to admission that one has failed in being masculine. Combined with the expectation that men are to be in control of their emotions, men may find themselves in the position of having many difficult issues or emotions to express and not having a safe way of communicating them directly or seeking help. In a similar way as women use "body talk" (Brown, 2007b; Malson, 1997)—using the body as a means to communicate what one feels unable to say directly—men use their bodies to communicate their struggles with the societal expectations placed on them. Instead of going through the difficult process of discussing their needs, dissatisfaction, frustrations, and struggles with masculinity, many men devote their energy to attaining a body that manifests the traits—strength and control—that they so desperately desire in other areas of their lives (Greenberg & Schoen, 2008). Considering the preceding conceptualization of why men develop AN and the meaning they convey through it, the following section will apply selected feminist and narrative techniques most relevant in working with MAN.

There are two primary reasons why a feminist narrative approach has been selected in addressing MAN. First, men's views of themselves and who they believe they are supposed to be are shaped by society. A feminist narrative approach provides a critical lens through which both the therapist and the client can deconstruct where such societal messages come from and what effect these messages have on clients' lived experiences. Second, people make sense of their lives through the construction of stories (Morgan, 2000). A feminist narrative approach engages clients in assessing whether the stories they live by are consistent with their lived experiences. If the dominant narrative of being strong and in control that a man is trying to live by does not line up with his lived experience, the client and the therapist enter into a process of identifying and reconstructing a preferable narrative that works better for him (Lock, Epston, & Maisel, 2004). One of the primary intentions in using a feminist narrative approach is to uncover and deconstruct the effect of social discourse on the experiences of clients. It is important to recognize

that this process is neither quick nor easy; asking clients to replace well-ingrained master narratives that are prevalent throughout much of their societal context with new narratives is likely to be difficult to initiate and maintain. In one's work with a client, it is necessary to openly discuss the ongoing challenge of implementing a new narrative. Particular emphasis should be placed on the strength and courage clients show in facing the potential challenges of this process, avoiding putting blame on the client when challenges arise. Although the following components are presented sequentially for the sake of clarity, actual therapy is not likely to proceed in such a linear fashion.

As with many models of therapy, a feminist narrative approach begins by positioning oneself with the client. Positioning from a feminist narrative perspective may consist of feminist contracting and getting a sense of how the client tells his story. As outlined above, power and control are often central to the development of MAN. Taking this into consideration, therapy should focus on providing the client with a measure of control over what is discussed in his work with the therapist. To do so, the therapist engages the client in setting a contract, establishing what will be discussed, the goals of therapy, and the pace at which therapy will progress (Brown, 1993b; Brown, Weber, & Ali, 2008). An example of contracting could be mutually agreeing to a maximum amount of time spent exercising on a daily basis. Such an agreed-upon stipulation addresses a potentially physically damaging aspect of AN—excessive exercise—while maintaining one of the benefits the client derives from AN, a sense of control over his body. Alongside contracting, the early stages of therapy include coming to a deeper understanding of the client's story. This includes attending to the specific language the client uses to tell his story (Carr, 1998) and, in turn, the meaning he attributes to the events that make up his story (White, 2007). By becoming familiar with the client's telling of his story, the therapist comes to see the purpose AN serves for the client, the context and effects of AN in his life, and the internalized messages the client tells himself that maintain AN in his life.

As the client unpacks his story, the therapist focuses the client on how his narrative of AN both affects and is affected by his view of masculinity. Masculinity is a social construction that influences men's everyday actions and interactions with the world around them (Payne, 2005). By exploring where the client's narrative of masculinity comes from and how it affects him, the client is able to consider whether this narrative is satisfactory to him. Such questions should resonate with the client's emotions and perceptions of his lived experience. Not only does

positioning indicate how AN affects the client's life, it helps the therapist gauge what other concerns or issues may be present, such as suicidal ideation, non-suicidal self-injury, or depression. Perhaps most important, positioning helps the client and therapist in forming a therapeutic alliance and communicating their expectations for therapy. It is within such an alliance based on trust that the client will be open to discuss his experience with an issue that has challenged his identity as a man.

Therapy then shifts to externalization conversations (White, 2007), helping "persons to identify the private stories and the cultural knowledges that they live by; those stories and knowledges that guide their lives and that speak to them of their identity" (White, 1991, p. 29). Externalizing allows clients to take a step back from their everyday lived experiences in order to recognize the narratives that shape how they live and their beliefs about both themselves and their relationships. The therapist poses the question of what issue has brought the client to therapy, allowing the client to describe how he experiences AN. Giving the client space to describe his experience allows him to control how his experience with AN is described. As the client shares his experience, the therapist invites the client to put a name to the problem (Payne, 1999; White, 2007). Naming helps to externalize the problem as being the problem, instead of the client being the problem (Lock, Epston, & Maisel, 2004; Lock, Epston, Maisel, & de Faria, 2005; White, 2000; White, 2003). Through externalization, the client and therapist move away from a pathologized view of the client's experience and toward a critical view of how his struggles are socially located (White, 1991; White, 2007). For men who struggle with the idea of having a "woman's problem," externalization may help them take a step back from their identification of being "anorexic." In seeing himself as separate from AN, the client can then begin to consider who he is beyond his AN identity. Interconnected with externalization is the deconstruction of the gendered societal context of MAN and how it affects the client's lived experience. Deconstruction consists of "'taking apart' (deconstructing) the beliefs, ideas and practices of the broader culture in which a person lives that are serving to assist the problem and the problem story" (Morgan, 2000, p. 45). Externalizing the problem and deconstructing its context may help the client in critically assessing the narrative by which he lives.

Relative influence questioning is useful in both externalizing the problem and deconstructing its social context. Such questioning can help to outline and evaluate the effects of AN in the client's life (White, 2007), as well as how the client affects AN. Possible questions include: *To what*

degree does AN affect your life? When you first noticed AN in your life, what do you think it was trying to tell you? What does AN say about you that most people don't know? To incorporate a more feminist perspective on the effects of AN, questions may be focused on deconstructing gendered social messages that inform clients about masculinity. For instance: *What do you think about a man struggling with AN? Where do you think these beliefs come from? What messages does society promote that tell men what they should be like? In what ways do you think these beliefs affect your experience with AN? What message is being conveyed through AN?* There are two reasons for using these questions. The first is to deconstruct the conflicting internalized messages that shape clients' views of self and masculinity, particularly in how these views affect a client's experience with AN. Regardless of whether clients are using AN to comply with and/or resist social discourse (Brown, 2005; Brown et al., 2008), their lives are still squarely based around their relationship with thinly-described narratives of masculinity. Deconstructing internalized messages allows clients to consider whether these narratives form a basis that is working for them. Second, these questions address underlying messages implicit in AN. What is the meaning behind AN? What does the client need to say? In identifying what needs to be said, the therapist and the client can collaborate on safe alternative ways that the client can say it.

In externalizing and deconstructing AN, the therapist may engage the client in "contextualizing eating disorders" (Brown et al., 2008), recognizing that AN is rooted in a significantly gendered cultural climate. Such contextualizing consists of entering into discussion with clients regarding social constructions of masculinity, how they affect the relationships of men in Western cultures with their bodies, and how they affect a given client. Soban (2006) states that it is necessary for therapists to "apply knowledge of the social structures that contribute to the construction of masculinity in order to better address the problem of anorexia nervosa in young men" (p. 253). Discussing the interconnection of social conceptions of masculinity and MAN educates clients about the social contexts in which MAN and masculinity co-exist. Sharing such information may help men with AN see their struggles as separate from those of women (Soban, 2006). MAN is a legitimate response for a man to have to social discourses of masculinity; it is not a display of being less of a man. Another benefit of discussing social discourse regarding masculinity is that it puts the client in a position to choose whether he wants to respond to such discourse and, if so, how he may do so.

Increasing client knowledge on such issues helps clients better understand their struggles and explore what they can do with such knowledge. Knowledge and power are inextricably interconnected (Foucault, 1978).

Coinciding with externalization, the client and therapist identify unique outcomes, occasions when the problem was not a problem or when the client successfully managed the problem (Carr, 1998; Lock, Epston, & Maisel, 2004; White, 2007). Regarding MAN, the problem may be that the client feels he does not meet the societal standard of being strong and/or in control (Andersen, 1992; DeAngelis, 1997; Greenberg & Schoen, 2008; Kearney-Cooke & Steichen-Asch, 1990; Soban, 2006); he may, in fact, feel quite weak and out of control. Unique outcomes of this dominant story are times when the client has lived outside of this self-perception of being weak and out of control. It should be noted that AN itself is a unique outcome in that it is a means for the client to gain a sense of strength and authority over his life. Upon uncovering unique outcomes, the therapist and the client engage in deconstructing the occasions in question. Deconstruction asks what it was about the outcome that allowed the client to effectively work with and not feel overcome by AN (Carr, 1998), how those who know the client would interpret such an occasion (Payne, 1999), and what effect this outcome has on the client's view of self (Carr, 1998). Emphasis should avoid focusing exclusively on occasions in which the client displayed control over AN, which neglects the meaning and purpose of AN in the client's life (Brown, Weber, & Ali, 2008; White, 2007). Unique outcomes should recognize times when the client was able to recognize the meaning inherent in AN without feeling the need to use AN to convey it. Such deconstruction helps the client move away from his story of weakness and ineffectuality and toward a richer narrative more closely aligned with his lived experience (Brown, 2003; Brown, Weber, & Ali, 2008; White & Epston, 1990).

In retelling a thicker narrative, landscape of action and landscape of consciousness questions may be used (Bruner, 1986; White, 2007; White & Epston, 1990). These questions help clients organize and make sense of their experiences (Brown, Weber, & Ali, 2008; White, 2007; White & Epston, 1990). Since clients make sense of their lives through the telling of stories, the stories they tell themselves flow into and colour all aspects of their lives. Narrowly-described stories result in constricted and self-defeating experiences and internal dialogue (Monk, 1997). Richly-described stories lead to more well-rounded experiences and dialogue. Using landscape questions allows men to link together various life events in retelling a preferred narrative. Landscape of action

questions focus on chronologically ordering unique outcomes (White, 1991), addressing what events happened, in what order they happened, when they happened, and what plot the client attributes to them (Carr, 1998; White, 2007). Landscape of consciousness questions consider the meaning clients attribute to their experiences, the effect these occasions have on them, their evaluation of the events, and their justification of the effects of these events (White, 1991; White, 2007). In constructing a client's landscape, attention should be given to what events or messages have contributed to his experience of being weak and ineffectual (Andersen, 1992; Greenberg & Schoen, 2008; Soban, 2006). Identifying where these messages have come from helps the client outline a preferred narrative in which he feels in control and powerful (Brown, 2003; Brown, Weber, & Ali, 2008). In working with MAN, landscape questions help clients organize occasions in which they exhibited personal agency and control over their lives without feeling the need to rely on AN behaviour. They help clients identify how their lives would look different without AN.

In telling a preferred narrative, outside witness groups and therapeutic documents may provide a client with support for his new narrative. An outside witness group consists of people in the client's life who know about his experience with AN and are willing to support him in implementing his preferred narrative (Carr, 1998). Due to the isolating and stigmatizing nature of AN (Stewart, 2004), witness groups provide the client with a sense of community support and accountability as he transitions from the old narrative to his retold story. Therapeutic documents are documents (i.e. lists, essays, letters) that speak to the client's perceived progress and discoveries (Payne, 1999). Such documents give the client's new narrative a sense of permanency, helping him in holding to his retold story (Payne, 1999).

David Epston's (1999) use of the anti-anorexia league is one of the more notable examples of using documents in working with people with AN. The league consists of documents submitted from people with AN, contributing to an alternative knowledge of AN entitled *anti-anorexia* (Epston, 1999). The purpose is for individuals to contribute to an anti-language while externalizing their experiences with AN (Epston, 1999; Maisel, Epston, & Borden, 2004). The concern with using supporting documents to generate an anti-discourse is that it totalizes individuals' experiences of AN, framing them as wholly malevolent external forces that actively victimize passive anorexics. Anti-anorexia discourse minimizes the inherent meaning and purposes within AN

(Brown, 2007b). If AN is a way for individuals to communicate what they struggle to say directly, it is integral to listen to what they are trying to say. Anti-anorexia does not accommodate this.

While the use of documents in working with AN has focused mostly on women (Epston, 1999), they are certainly applicable in working with men. The question is whether documents should be specifically tailored to working with men and, if so, what form these should take. The use of gender-neutral documents may work well with a male population. For instance, a male client may take to the idea of constructing an essay that outlines his preferred narrative. The client may then circulate the completed essay among individuals whom he would like to support him in enacting his new narrative, who would then read and sign the document as a show of their support. More male-centred documents could take the form of a client's composing and circulating a letter that reviews his experience of how social discourse of masculinity has affected his relationship with both his identity and his body. Since documents have generally been used in such a way that totalizes clients' issues as being without any redeeming qualities, it is integral to recognize the meaning inherent in one's experience with AN.

Re-membering is the process of bringing past figures in the client's life into their present experience (White, 2007). This may include people who have either directly (family, friends) or indirectly (religious figures, favorite writers) influenced the client (Payne, 1999). Through re-membering, the client allows the effect that such people have had in his life to continue. The client may exclude certain people whom he feels would be detrimental to his retold narrative (Payne, 1999). Such people may include those who may have contributed to the maintenance of the client's problem-filled narrative.

These techniques are useful in that they help the client deconstruct his thin narrative of what it means to be a man with AN; finding past occasions that counteract this old narrative; retelling a preferred narrative that fits better with his lived experience; and gathering support for his retold narrative. The next section will focus on the application of a feminist narrative approach to MAN to the case study of Jackson.

Jackson is a 19-year old currently in his first year of university. Jackson states he recently went to his doctor because of feelings of depression and that, while there, his doctor expressed concerns about his low weight. Since the appointment, Jackson has begun wondering if he might have an eating disorder. He reports that since high school he has utilized weight training and dieting as a means of gaining muscle mass.

Jackson says he struggles to add muscle while keeping his body fat low. He attributes his pursuit of lean muscle mass to being teased for being overweight in elementary school. As he began to go to the gym and cut out fatty foods, he began losing weight, resulting in compliments from his peers. As Jackson received more compliments about how he looked, he would work out all the more. He says that he defines himself based on how his body looks. His parents separated during the summer before he entered university. In light of their separation, Jackson says he feels like his life has been spinning out of control. He is very close with both parents. Jackson reports increased exercise and food restriction since the separation. Jackson states that he feels overwhelmed by the busyness of university; even though his grades have been good, he experiences very high levels of stress, frequent feelings of faintness and fatigue, and has not gotten to know many other students. Jackson says he uses exercise and healthy eating as a way to manage his stress. Jackson lives in residence, but regularly contacts both of his parents and his 22-year old brother. His family knows about his concerns regarding AN and are supportive of him. Jackson reports that he is a Christian and that his faith has been a source of strength.

For the sake of this paper, this case study will be discussed in the first person. In our first session, Jackson seemed hesitant to discuss his struggles with AN. I began positioning myself with him by letting him know about my therapeutic approach and expectations for therapy. I stated that I work from a feminist narrative perspective, meaning that I believe that all persons have their own unique story that explains who they are, their relationships, and how they interpret the world around them. I explained that I believe that how we view ourselves is influenced by the societal messages we take in; these messages tend to emphasize expectations of how we should live our lives given our gender, sexuality, and culture, among other factors. I invited Jackson to share his expectations of therapy and his story with me, saying, *I believe that each person has a story that only he or she can tell. I am interested to hear whatever it is you are willing to share with me about your story. Would you be willing to tell me what you would like to get out of our time together?* As Jackson discussed his story and his expectations for therapy, I paid close attention to the language he used. The terms he used most often were "depressed," "stressed," "fatigued," and "out of control." When asked specifically about his feeling of being "out of control," Jackson said that there is so much stress in his life and that he is powerless to do anything about it. I persisted, asking him whether he

connects his experience of AN with his feeling of life being out of control. Jackson replied that he feels strong and in control when he works out, stating, "When I'm lifting weights, I don't feel all the stress, like school and stuff. By the time I leave the gym, I start feeling stressed again."

In the same session, I began working with Jackson in externalizing his experience with AN. Jackson said that he has taken to calling it ED, short for "eating disorder," mainly because it sounds "more like something a guy would have," I was able to ask a few externalizing and relative influencing questions. For instance, I asked, *In what ways does ED help you feel more in control of your life?* The intent of this question was to separate Jackson's experience as being influenced by ED from the idea of Jackson being ED. It also gave Jackson a chance to tell me more of how his feeling of control/out-of-control was connected with his experience of ED. Jackson's response to the question was that, in the midst of his parents' separation and school, ED allowed him to grasp on to a part of his life—his body—that he felt he had power over. It was one thing that still seemed within his authority.

Throughout our following session, we focused on the effect of societal expectations of masculinity on Jackson's experience with ED. In response to Jackson's stating that he views AN as an issue he associates with women rather than men, I asked him what he thinks of a man being anorexic. This led to a brief discussion of what Jackson sees as being the characteristics that men are supposed to possess. He replied that men are supposed to be successful, powerful, and "able to handle whatever comes up." As homework, I asked Jackson to write out a paragraph addressing where he feels these expectations of males come from. This homework helped set up an ongoing conversation throughout therapy of how societal expectations of masculinity are interconnected with men's everyday experiences, with particular emphasis on men's ability to openly express themselves and their relationships with their bodies.

Coinciding with the discussion on societal views of masculinity, I introduced the idea of "body talk" (Brown, 2007b; Brown et al., 2008; Malson, 1997). To do so, I explained: *In the face of our difficulties, it can be difficult to say what's troubling us. Some people use their bodies to speak for them. They may restrict food, exercise, or use other means of controlling their bodies to communicate what they may have trouble saying outright.* The purpose in discussing the interconnection of masculinity and MAN, as well as the use of body talk, was to give Jackson an increased awareness of the social construction of masculinity

and how this affects him specifically. Such awareness was intended to help him understand the context of his experience and put him in a position of being able to choose whether he wants to side with or oppose such social discourse.

In uncovering unique outcomes, Jackson and I discussed occasions when he effectively managed his life stressors without having to utilize ED. Discussion of unique outcomes coincided with the question of what meaning Jackson perceived to be behind ED. Bringing ED's meaning to the forefront was a means of recognizing that ED has served a constructive purpose in Jackson's life. In recognizing ED's purpose, Jackson was able to consider less problematic ways to convey that same meaning. Identifying unique outcomes afforded Jackson supporting evidence for his preferred narrative, displaying times when he ably managed his struggles without needing ED. The questions I used with Jackson included: *What do you think ED has been trying to tell you? What have you been trying to say through ED? Have there been times you've been able to effectively say the same thing without needing ED's help? What was different about that situation? What does that occasion say about your ability to deal with stress?* These questions drew Jackson's attention to the areas of his life in which he used ED to speak for him, while also exploring ways in which he has displayed that he can say what needs to be said without ED's help. In identifying unique outcomes, I was able to use landscape of action and consciousness questions to help order the events that best supported his story of being able to manage his stressors and say what he needs to say directly without ED, while uncovering what such occasions say about him and how they support a preferred narrative of his lived experience.

As Jackson developed his retold narrative during our discussions, I asked him how he planned to support his new story, with emphasis on whether there was anyone he trusted enough to enlist to help supporting him in the living out of his new story. Jackson said his mother and father had encouraged him in overcoming his struggles. Early in our first session, Jackson stated that he might be willing to join a support group at some point, but that he was not willing to do so yet. As therapy progressed, Jackson invited his parents into a couple of our sessions to discuss whether they were willing to support his new narrative and how they may be able to do so. Jackson's parents were willing to be of assistance in whatever way he requested. Jackson maintained through the rest of therapy that he did not feel ready to join a support group since, as

he put it, "I would likely be the only guy." However, he did express interest in starting his own group one day for "guys with anorexia."

In our last few sessions together, Jackson was more able to identify the purpose ED had served in his life, while also recognizing that he had displayed on multiple occasions his ability to express effectively his experiences and emotions without needing ED. To help Jackson integrate what we had discussed in our time together into his everyday life, I broached the idea of using a supportive document. Between our final two sessions, I asked Jackson to compose a document consisting of his beliefs of what he feels it means to be a man, why he feels this way, and how these beliefs will affect his everyday life. I asked Jackson whom he felt comfortable with asking to read and "sign off" on the document. He stated that he wanted his brother to be his "witness." Jackson completed the document for our final session, with his brother's signature at the bottom as a show of support as Jackson would work toward living out the contents of his exposition. There were several purposes for this activity. First, it will help Jackson to keep *his* beliefs about masculinity at the forefront of his mind. Second, by having his brother read and sign the document, Jackson was able to enlist support for his retold narrative as well as generate awareness within his social network regarding MAN and masculinity. Third, constructing and circulating this document provides Jackson with a means of influence and efficacy in his social context while taking ownership of how he views the world around him.

As well as supportive documents, I worked with Jackson in identifying people whom he wanted to re-member, to draw into the narrative that he was constructing. Jackson identified that the document he wrote was a way of keeping the positive influence his brother has had on him as a key influence moving forward. Considering how important Jackson says his faith is to him, we discussed how he could re-member people who have had an effect on his spiritual wellbeing, which he had expressed as an integral part of his life. Jackson identified St. Paul as someone who signified the spiritual strength and perseverance he needed to live his life in a way that would align his values with his lived experience. Jackson and I discussed the ways in which he could integrate the effect of both his brother and St. Paul into his everyday life.

In my work with Jackson, my intention was to provide him with a therapeutic environment in which to explore his experience with AN. This included conversing about what his experience looked like; externalizing and naming his experience with AN; drawing his internal dialogue of what it meant to him to be a man, with particular emphasis on

what it means to be a man struggling with AN; and identifying the influence of social discourse on his relationships with both himself and the world around him. Intertwined with such discussion included the process of locating unique outcomes that told a counter story to his narrow conception of himself and beginning the process of retelling the narrative that he lives by. My hope is that, by my assisting Jackson in reconstructing his narrative and helping him support it through enlisting witnesses and using supportive documents, he will be able to move forward in his life without the need to rely on ED.

This paper has formulated a feminist narrative conceptualization of and application to MAN. In doing so, a review of the diagnostic criteria of AN and academic literature regarding both MAN and masculinity was provided. The most prominent themes in the literature included emotional restriction among males, the idealization of the male body as lean and muscular, and an attribution of certain socially-defined traits to males—including strength, control, and success. Such societal conceptions of what men are supposed to be influence how men interact with the world around them, their relationships to themselves and their bodies, and their degree of satisfaction with their lives. Males whose lives do not align with such narrow social discourse may feel hopelessly weak and ineffectual. As a result, men may strive for a sense of power and control over their lives by exerting strict self-regulation of what they perceive to be the only thing in their lives they can control—their bodies.

While recognizing that most reported cases of AN are among women, men do struggle with AN and it carries significant meaning for them. This paper has amalgamated several key themes from the academic literature and presented a possible feminist narrative way of viewing MAN. It is the author's hope that, akin to the progress that has been made in coming to a richer discourse of AN among women, the story of MAN will continue to be discussed in the literature in ever-greater depth.

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