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Early life loss and trauma:

Eating Disorder Onset in Middle Aged Male

A Case Study

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Abstract

The onset of an eating disorder in middle age men is poorly researched as are eating disorders in men generally. Therefore life events that influence eating disorders in men including delayed onset of an eating disorder remains unknown. Given the limited understanding of males with eating disorders and limited access to large samples of men with eating disorders, an in-depth analysis of a single case of a male in middle age with an eating disorder was chosen to gain insight and understanding into this phenomenon. A *Life History* approach explored the case of Joseph (pseudonym), who was diagnosed at age 44 with an Eating Disorder Not Otherwise Specified. Data were collected through: a) life course open ended questioning through interviews; b) written statements; c) comments on transcripts. Three themes emerged: *loss and unworthiness, becoming bigger and wanting to change* reflecting eating behaviors associated with attachment disruption, loss and trauma, body dissatisfaction, and negative affect. Later in life, an emotional ‘tipping point’ precipitated an eating disorder. Results indicate traumatic loss leading to early attachment disruption as influential in Joseph’s delayed onset of an eating disorder. The value of thorough narrative life histories during therapy when eating disorders occur late in life is discussed as well as the significance for men.

Key words: *eating disorders; older males; loss; trauma; attachment disruption.*

Introduction

Eating disorders are serious and frequently fatal mental illnesses. However, eating disorders are generally considered to be low prevalence diseases more common among females than among males. Overall, research is limited regarding how and why eating disorders develop in males.

Even less is known about why males develop eating disorders later in life. This present study is concerned with enhancing our knowledge of late onset eating disorders in males over 40. Using a Case Study Life History approach (Denzin, 1989a; 1989b) we sought to explore the subjective understanding of gender specific life events that may have contributed to this unique phenomenon, that of delayed onset of an eating disorder in a male over 40.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) recognises two distinct eating disorders, anorexia nervosa and bulimia nervosa. It also provides a classification, eating disorder not otherwise specified (EDNOS) for eating disorders of clinical severity that do not meet the criteria for anorexia or bulimia. While anorexia nervosa is characterised by extremely low body weight and fear of its increasing, bulimia nervosa involves repeated binge eating and compensatory behaviours. EDNOS includes sub-threshold variants of these disorders and other syndromes such as binge eating disorder (BED).

Eating disorders in males are probably under-reported due to the stigma associated with these largely female conditions (Morgan, 2008). They may also be less easily recognised by clinicians because most eating disorders in males do not meet criteria for anorexia nervosa or bulimia nervosa and are therefore likely classified as EDNOS. For example the lean muscularity of the ideal male body protects against the low weight required for a diagnosis of anorexia nervosa but the pursuit of this ideal can still lead to disordered eating (Crosscope-Happel, Hutchins, Getz & Hayes, 2000; Pope, Phillips, & Olivardia, 2000; Raevuori, Keski-Rahkonen, Hoek, 2006; Jones & Morgan, 2010). Hudson, Hiripi, Pope, & Kessler (2007) reported that males had lower lifetime prevalence rates than females for anorexia nervosa (0.3% v 0.9%), bulimia nervosa (0.5% v 1.5%) and BED (2.0% v 3.5%), but higher rates for sub-threshold BED (1.9% v 0.6%). Unfortunately, it is difficult to obtain accurate estimates of prevalence because of the

tendency of people with eating disorders to conceal their illness and avoid professional help (Hoek, 2006).

Onset of eating disorders typically occurs in adolescence or early adulthood. Rates of onset are low over the age of 25 (Hay, 2004; Hoek, 2006; Hudson et al., 2007, Patrick & Stahl, 2009) and rarely reported over the age of 40. The few studies available include two patients with onset after 40 (Mynors-Wallis, Treasure, & Chee, 1992), a single case study with onset at 41 (Gupta, 1990), two patients with onset in the 40's (Tobin, Molteni, & Elin, 1995) and eleven patients with onset over the age of 40 (Beck, Casper, & Andersen, 1996). Kally and Cumella (2008) reported 40 cases with onset at 40 or above. All of the above patients were female. One case of anorexia nervosa symptoms has been reported in a 72 year old male who was known to have a long history of food preoccupation and restrictive eating habits (Manejias, Parke, Yager, & Apfeldorf, 2008).

The growing body of research on eating disorders in younger males frequently makes comparisons with eating disorders in females (Bramon-Bosch, Troop & Treasure, 2000; Braun, Sunday, Huang, and Halmi, 1999; Button, Aldridge & Palmer, 2008; Carlat, Camargo & Herzog, 1997; Crisp, 2006; Crosscope-Happel et al., 2000; Fernandez-Aranda, Aitken, Badia, et al., 2004; Striegel-Moore, Rosselli, Perrin, et al., 2009; Strober, Freeman, Lampert, et al., 2006). Most of these comparisons either explicitly concentrate on younger people (Austin, Ziyadeh, Kahn, et al., 2004; Lewinsohn, Seeley, Moerk & Striegel-Moore, 2002; Mitchell & Mazzeo, 2005; Raevuori et al. 2008) or are based on predominantly young samples (e.g. Pritchard, 2008). Many studies have reported that eating disorders present similarly in males and females (Bramon-Bosch, Troop & Treasure, 2000; Braun, Sunday, Huang & Halmi, 1999; Carlat, Camargo, & Herzog, 1997; Crosscope-Happel, Hutchins, Getz & Hayes, 2000; Fernandez-Aranda et al., 2004; Strober, Freeman, Lampert, et al., 2006; Woodside, Garfinkel, Lin, et al., 2001). However, differences are noted, though the strength and consistency of evidence is variable. On the whole, females

make greater use than males of laxative, diuretic, diet pills, vomiting and fasting, but not exercise and other compensatory behaviours (Anderson & Bulik, 2004; Striegel-Moore et al., 2009). Not all studies however were as conclusive with Lewinsohn, Seeley, Moerk & Striegel-Moore, (2002) reporting greater female use of inappropriate compensatory behaviours. Food hoarding is more common among females (Crisp, 2006) who also report binge eating, body checking and avoidance more commonly than males (Striegel-Moore et al., 2009).

Although risk factors for eating disorder are varied and common (Stice, 2002) there are gender specific risks for males including premorbid obesity (Crosscope-Happel et al., 2000; Fernandez-Aranda et al., 2004), parental obesity (Carlat et al., 1997; Crisp, 2006), parental divorce (Braun et al., 1999), involvement in sport (Crosscope-Happel et al., 2000), family over-protectiveness/enmeshment (Crisp, 2006), high psychiatric comorbidity (Bramon-Bosch et al., 2000; Carlat et al., 1997; Raevuori et al. 2008), gender identity concerns, and homosexuality (Austin et al., 2004; Bramon-Bosch et al., 2000; Carlat et al., 1997; Crosscope-Happel et al., 2000).

Trauma and loss in early life can set the stage for later behaviours that inadvertently distract from psychological pain and distress. As a consequence, eating disorders are often associated with a history of childhood physical abuse and neglect (Mitchell & Mazzeo, 2005) with males experiencing eating disorders reporting higher incidences of being beaten in childhood, mother-child abuse, and sexual abuse, than non-eating disordered men (Olivardia, Pope, Mangweth & Hudson, 1995).

However, although traumatic and complex challenging events can have negative consequences for an individual, the potential for positive psychological growth is now recognised following a wide range of life events and distress (see Joseph, 2012). Furthermore, those experiencing ongoing distress from vicarious exposure to parental trauma as children, or partner

trauma, have used those experiences to redefine their own lives positively (McCormack, Hagger & Joseph, 2011; McCormack & Sly, 2013). This study is interested in both the positive and negative interpretations that influence individual eating patterns and behaviours in males.

Although research has found many similarities and differences in the presentation of eating disorders in males and females, the nature and extent of these presentations are little understood. As such, how individuals might positively or negative interpret these experiences is unknown. What we do know comes from research on populations mostly comprised of adolescents and young adults, and theories that reference their developmental stage. Males who present with eating disorders in later life may exhibit a very different clinical picture and challenge clinical understanding of these debilitating conditions.

Qualitative methods are providing insight into the hermeneutic possibilities that individuals bring to both primary and secondary traumatic, painful, and chronic life events (Smith, Flowers & Larkin, 2009), and this is relevant to research into early life trauma and late onset eating disorders. Therefore, the aim of this study is to explore the ‘lived’ experience of a male with middle-age onset of an eating disorder. An in-depth, thematic analysis of a single life history case study was conducted to understand how the participant made meaning of this unique experience.

Method

Participant

Joseph (pseudonym), aged 45 years, was approached to participate in this case study given his unique understanding of experiencing an eating disorder in middle age. Joseph was provided with details of the research and informed consent was obtained. Ethical clearance was gained through the University. Joseph was born in England in 1965, the second of three children. When he was eight months old, his older brother died of cancer. The family moved to Australia

when Joseph was 5. At the time of the study he was an information management professional who had developed a severe eating disorder at age 43 years and lost one third of his body weight in seven months. No medical explanation was able to shed light on the weight loss. At that time he sought psychological therapy for a period of two years and was diagnosed with an Eating Disorder Not otherwise Specified (EDNOS). Joseph's history taking revealed significant trauma as a child as well as experiences of depression and anxiety over his lifetime which was relevant to his diagnosis of EDNOS and treatment.

Procedure

In line with a life-history method, data was obtained from several sources. First, an interview schedule was developed (Appendix 1 & 2) for three two-hour interviews that were conducted over consecutive weeks. A follow-up interview was conducted after transcribing to further probe interpretation and meaning (see Appendix 3) The first interview, conducted in Joseph's home, was comprised of a series of open-ended interviews structured around Joseph's life course, to maximise the breadth of information obtained (see Appendix 1). For the second and third interviews, a supplementary interview schedule (see Appendix 2) was introduced, based on the EDQ 9.0 (Mitchell, 2008) to obtain specific information about eating and weight related behaviours. The follow-up interview probed for affective understanding of cognitive interpretations within the data (see Appendix 3). Each interview was recorded on a digital voice recorder. Data from the interviews were transcribed verbatim. Second, Joseph provided written statements, including comments on the interview transcripts, and spreadsheets he had used to monitored his weight loss. Third, he completed an Eating Disorder Inventory-3 (EDI-3), and a self-report measure of psychological traits shown to be clinically relevant in individuals with eating disorders (Garner, 2004). An individual case study was chosen as the most suitable way of investigating the data which reflects a subjective continuum of events across a lifetime.

Epistemology

Epistemologically this study relies on the philosophies of phenomenology, critical realism and symbolic interactionism by describing the way in which the world of Joseph is socially constructed, interpreted and understood around this unique phenomenon (Smith, 2004; Spinelli, 2005). As such it provided a platform for exploring the complexities of a late onset eating disorder through a process of understanding and interpretation. As access to the individual's world is always mediated, a critical realist position is a comfortable fit with symbolic interactionism which is concerned with the way people: a) act towards things based on their subjective meaning; b) bring meaning to social interaction; and c) interpret and modify fluid and ambiguous meaning.

Drawing on these philosophies, the authors sought the *essence* or the underlying *meaning making* of this participant's subjective 'lived' experiences relating to his late onset eating disabilities. The theories of trauma and growth influenced the interpretation of data and the development of the themes (Braun & Clarke, 2006). At the same time, the authors were challenged to reflect on their own subjectivity and knowledge of the phenomenon under investigation, and to consciously recognise their own biases and presuppositions that may have interfered with interpretation of data (Heidegger 1927/1962; Gadamer, 1983).

Analytic Strategy

As there is a paucity of research into the experiences and life history impacting on late onset eating disorders, a qualitative, Life History methodology was used (Cole & Knowles, 2001). The authors felt that this poorly understood phenomenon was best viewed through the subjective 'lived' experience lens of the participant and thereby inform future research. It did not aim to offer generalizability or cause and effect. This method emphasises the inner experience

of individuals and its connection with the phases and events of their life course. The Life History method is particularly suited to the study of eating disorders, where events across the life course, both positive and negative, (disturbances in early attachment, parental control and maltreatment, gender role orientation, and early learning about self-control, eating, and body shape and weight), have been proposed as predisposing factors for the development of a late onset eating disorder (Koskina & Giovazolias, 2010; McEwen & Flouri, 2009). Similarly, a life history approach allowed the participant to subjectively explore his experiences in multiple forms. It also provided a breadth of data that could be analyzed through a method of reduction to specific interactions, statements and themes in search for all possible meanings. The interviews were structured around the phases of Joseph's life. For each phase, Joseph was asked to report on his perception of the following experiences: activities, major events, relationships, physical and mental health, substance use; and his relationship with his body and with food, including weight, disordered eating, exercise, other weight related behaviours and body image concerns.

Analysis and Results

Joseph's perceptual narrative of his life journey and his relationship with eating was constructed from the information obtained in the interviews, written statements, and spreadsheets as well as a follow up interview targeting the affective and cognitive elements of his experience. Joseph's life may be conceptualised as comprising ten distinct phases some of which contain distinct sub-phases. The major phases are described in Table 1:

Insert Table 1 here:

Three distinct themes emerged throughout these phases: *Loss and Unworthiness*, *Becoming Bigger*, and *Wanting to Change*. A theory of the origin and maintenance of Joseph's eating disorder was developed and discussed in the context of both his beliefs, and the emotional intensity with which those beliefs are experienced by Joseph.

Loss and unworthiness

Joseph believed that early family of origin cumulative losses and negative early life events impacted on his feelings of unworthiness. From a personal narrative perspective, Joseph was able to recall events and family history. However, the intensity of his emotions left him feeling a ‘numbness’ and ‘a mental block’ when trying to bring meaning to his feelings around his parents’ treatment of him, particularly his father. In the earlier interview, Joseph was able to narrate the early life events that he believed influenced his sense of self, relationship patterns and eating behaviours but was left struggling to make sense of that ‘numbness’ and ‘mental block’. In the follow-up interview, the researchers explored Joseph’s beliefs in relation to his status in the family and based on his mother’s advice, on his role as a family member. There were also certain emotional responses noticed as a consequence of these beliefs that remained over the years .

Trauma and abuse/becoming invisible:

The first experience of family loss Joseph believed influenced the way he viewed his importance within the family. He recognised this event as pivotal in learning to be ‘invisible’ within the family while his parents were preoccupied with his terminally ill sibling:

You can just imagine that probably from the time I was born a lot of attention was placed on my older brother and taking him to hospital and things like that. And then of course in dealing with his death I imagine that things were not necessarily the happiest.

However, it is his memory of immigrating to Australia at 5 years of age that seems to consciously consolidate for Joseph, his need to be ‘invisible’ and avoid drawing attention to himself. When leaving behind a supportive family network he recalled being told that he would have to be good for his mother. Joseph came to value his mother’s self-sacrifice,

Her parents were still alive in England and she was an only child, so it must have been wrenching

and thereby came to believe that there was value in putting others' needs ahead of his own needs. In emulating his mother, her perceived unhappiness was also something for him to embrace: "I don't deserve to be happy". Therefore Joseph chose solitary activities or activities that benefited others rather than himself throughout his life. This included intimate relationships. For example, Joseph described that he found decision making difficult and waited to be directed in his current relationship: "I can't do something just for me, that doesn't sit right for me".

Joseph's father first left the family in Australia when Joseph was 8 years old. In the follow-up interview Joseph explored the intensity of his feelings towards his father particularly his memory of him as an angry, controlling, and emotionally abusive man whose needs came before others. Joseph was surprised by his response to this memory and reflected on how these childhood events had impacted on his future eating habits. First, he described feeling devastated by his father's departure. He believed he was the only one of his friends without a father and that he was not adequately socialised into the masculine role. He remembers that the usual solitary boy became 'disruptive' at school:

All of a sudden I come home one day and Dad was gone. I think it was around Grade 3 or 4. That was around when I started getting comments on the reports about not joining in, about being a little disruptive.

While recounting these memories, Joseph became tearful and was visibly shaken stating that despite his efforts to remain 'invisible' to his father, he had still left him. Despite its failure

to gain his father's care and love, he deliberately sought invisibility throughout his adolescence and adult life to keep him safe from emotional hurt:

“I wanted to be invisible and unnoticed and not draw attention to myself”.

When probed further on the origin of his feelings of invisibility, Joseph was able to recognise that the early life practice of remaining invisible to an abusive father had become life-long self-protective behaviours:

“If I was quiet and invisible then dad would leave me alone”.

Second, in recognising that his fear of his father's anger and abuse left him unable to challenge his father, he accepted his father's abuse as his mother had self-sacrificed her needs. Joseph described his eating disorder as an “an obvious way of being invisible”. When he became emaciated: “If no one sees me, I can't fail.”

Similarly, Joseph was asked how his father's message to him as a child not only influenced his thinking as an adult but impacted on the intensity of his feelings. He described that feelings of abandonment and unworthiness plagued him during adult relationships and that partners left him just as his father had left him. He felt that his failure in adult relationships was driven by the inner voice of his father: “I don't deserve to be treated well”. Furthermore, as the years passed and relationships failed, his father's message that he had done something wrong and deserved to be punished was self administered his eating disorder. These feelings were so intense that when Joseph felt bad about himself he would not only punish himself through eating or not eating, but would ‘often deliberately kick myself’ or doing something that caused pain and injury.

Punishment/worthless adult:

Unable to feel a sense of worth, “Like I was discarded as no good” his father's legacy was an inaccurate account of himself. He believed he deserved punishment and self harm became the vehicle:

I felt that dad leaving me and mum was punishment ... Not eating, exercising until I feel pain and hitting myself are all ways I punish myself ... I don't deserve to feel good.

These beliefs continued throughout his life. His father's comings and goings from the family and his mother's health needs had reinforced the belief that he was unimportant and others' needs more important than his own:

Since as long as I can remember, I've never liked myself and don't understand why others would like me either.

Fear of abandonment and rejection inhibited healthy adult attachment. In his adolescence he was unable to talk with anyone about his feelings. When he finally sought counselling, his habit of prioritising the needs of others often sabotaged his therapeutic work:

It is legitimate to do things for others but not for me.

Though Joseph's father returned home two or three times while Joseph was in High School, the last return (when Joseph was 15 and after his father had gone blind following a stroke) was the longest and most difficult for Joseph. Joseph recalled that his father was "irritable and intimidating". The return of this invalidating 'not good enough' message would plague him throughout adult life

Joseph was surprised that he felt relief when at 16 years of age his father left for the last time. However, equally surprising to Joseph, self loathing and feelings of guilt emerged. He recalled the impact of this final assault led him to resort to excessive eating in an attempt to sooth these negative feelings. As his weight began to escalate unwanted attention was drawn to his appearance and behaviour at school.. 'Invisibility' was challenged. He frequently sought to avoid school by feigning, and then inducing, illness. Over time, inducing vomiting became an automatic response to stressful situations:

... had a massive plate of food and pigged out until I was sick.

Shame and self harm became partners for validating feelings of unworthiness.

‘Deliberately going out in the rain and exacerbating injuries’ was becoming a regular practice.

He stated that he did these things partly to ‘feel something, partly to experience pain like the pain other people experience and partly to seek attention’, but with the intention of not getting attention, and thereby proving that he was not worthy of attention. In adult life Joseph continued to hurt himself through hitting, and injuring himself to feel something negative:

I feel guilty if I feel good ... I don’t deserve to feel good.

Unable to connect/becoming isolated:

Towards the end of High School, Joseph discovered that his preferred career path was closed to him. This reinforced his belief that he had no control of his life. Early attempts at relationships with girls were equally unsuccessful. He did have one significant 18 month relationship with a woman 8 years his senior. However, feeling a sense of loss and hurt when it ended, he remembered thinking that it was best not to become too attached to anyone or anything.

Joseph spent a year on unemployment benefits after which he went to university and studied psychology. Though he graduated, from the course he concluded that he was not fit to help people, and was again unemployed for a year. When asked about his current employment and whether he enjoys it, Joseph stated he doesn’t enjoy it at all but “couldn’t let people down” by changing careers or his role. He explained that he really struggled to see how further study which would benefit him could be justified as benefitting others was the only way change would make it legitimate to him.

Joseph reported that he has always thought he was overweight, and probably has been overweight for most of his life. However, throughout his childhood and youth, his eating was unremarkable: he ate regular meals, occasionally overindulged, and occasionally skipped a meal.

It was not until he began to study at university that Joseph started using diet pills to control his weight, and had a brief episode of starvation when, unable to face a woman with whom he had had a relationship, he isolated himself in his room and spent a week consuming nothing but appetite suppressing fibre drink. He believed that if he was thinner he may be less repugnant and might stand a chance in relationships.

These intense episodes resurrected the dichotomous feelings of hope and invalidation that he had experienced with his father. He described it as a seesaw feeling and an ‘inability to read messages’ reinforcing isolation and an ‘inability to connect’. In these early relationship attempts, he felt unable to advocate for his own needs and in a follow-up interview recognised that he participated in a revolving and powerless situation similar to that with his father:

Do you want to come over tonight? ...“I don’t want to see you again.

Joseph remembered internalising this as him doing ‘something wrong’. He recalled that these intense feelings were expressed through isolation and poor self-care. Joseph retreated to his university room alone and: “effectively spent a week where I couldn’t eat a thing”. After a week he collapsed in class and started eating again.

Unable to connect in a meaningful relationship, his sense of isolation intensified. He now entered a period where he stopped trying to please others with his appearance. He stopped using diet pills, and paid little attention to his presentation. He reached 90 kg (BMI 29.4), his maximum weight to that time, and then dropped to 85 kg, (BMI 27.8) after he injured his back playing hockey. Joseph sense of isolation escalated leaving him feeling again that he deserved to be punished.

Becoming bigger

At 25 Joseph joined the Public Service. He has spent most of the time since working with data, has completed further postgraduate degrees, and for much of the last 20 years has defined himself by his work.

Joseph remembers that during much of this time he felt worthless and unlovable. Becoming bigger was a form of acceptable punishment: “why should I take care of myself?”. In a follow-up interview Joseph reaffirmed that becoming bigger at this stage of life helped him remain invisible and isolated. But he was also becoming conscious of the complexity of his behaviours and how they inhibited social engagement and change. He recognised that he was “invisible at work” too much of the time, not engaging with others socially and trying to stay “under the radar”. He reported that he had wanted to change roles and do something more interesting but was unable to because “that would mean drawing attention to myself”. It would also challenge his beliefs: “doing something that I enjoy”. During the follow-up interview he was able to muse over the dilemmas he had so often faced:

..... I have a real problem with doing things just for myself ... I might also let (my workplace) down (by leaving).

At the end of his first year in the public service, Joseph entered a relationship and married Karen a year later. He recalled that before long, he and his wife developed different interests and lived separate lives. Joseph felt “trapped” in an unhappy marriage. On further probing Joseph stated that at the time he was unable to leave even though he knew he was unhappy because earlier life practices of being invisible and not prioritising his own needs sabotaged his actions:

... if I just stayed out of the way, it was ok.....I was waiting for her to make the decision to leave.

He cooked to express himself, overindulged on food and alcohol, and put on weight. By the end of the marriage Joseph weighed 100 kg (BMI 33.0). In a later interview he again recognised this ‘overeating’ as a form of “self-harm and punishment for not being good enough”. With insight, he also recognised that the marriage had supported his self-abuse and disclosed that his drug and alcohol problems started during this relationship as “she was” his main supplier:

It wasn’t good for me to be with her and I see that now.

Joseph had made no attempts at intake restriction or compensation, and his weight continued to accelerate to 110 kg (BMI 36.3) when he moved in with Karen (a pseudonym). Joseph described his relationship with Karen as “unhealthy”.

It was always one of those situations where I couldn’t win. I have never wanted to be where I wasn’t wanted and so when she handed me this letter (*to leave*), after getting over the initial shock, I went “Oh right then”. ...“Right, you want me to move out, then fine, OK” but apparently I was supposed to fight ... It was not a very healthy relationship.

His harmful eating, drinking and smoking cannabis continued to increase when he was alone. By the end of the marriage he was bingeing at least twice a week and probably met criteria for BED. His weight increased to 120kg (BMI 39.6) and he made half-hearted attempts to lose weight without changing his eating. Joseph reported that when Karen “kicked him out”, he was ready to leave. He recognised a pattern in relationships. Similar to his previous relationship, he had felt unhappy in the marriage for some time but was waiting for the other person to make the decision. Negative self-talk would contribute to indecision. Without healthy strategies to manage this Joseph used drugs and alcohol to switch off and “escape my head”.

Joseph moved out and spent eight months alone. He felt out of control in most aspects of his life. He was overeating, drinking 2/3 of a bottle of spirits (16 standard drinks) 2 to 3 times a

week and smoking cannabis every night. By May 2006, Joseph weighed 125 kg (BMI 41.3) and experienced chest pain and tachycardia. He consulted his GP who warned that he was “heading towards an early grave”. Shortly afterwards Joseph fell down the stairs at home and, as he lay on the floor, he decided it was time to seek help to change his life patterns. Unfortunately, the focus remained one of focus on others and “not be a burden on others” rather than one of self-care and worthiness.

Joseph desire to change at that time was short lived. He moved out of the marriage and “hibernated”, living on takeaway food, alcohol and cannabis. Joseph’s mother, died in this year after a short illness. He described loosing her as the worst thing that he had ever been through. She was the only person with whom he had had an ongoing and meaningful relationship:

The one person I would never want to disappoint or cause waves or trouble for was no longer there and I was scared of whom or what would hold me accountable now.

Joseph stated he felt overwhelmed with sadness at the loss of his mother. He was also overwhelmed with ‘numbness’ in regards to himself. When asked to explore how feeling overwhelmed with sadness and numbness could co-exist, he was able to describe sadness as a physical feeling which linked him to self-destructive behaviours. The combination of self harming and negative feelings maintained and legitimised beliefs of poor self-worth:

to legitimie how badly I was feeling about myself ... if I had a physical injury, I could feel pain ... and that was acceptable to me.

Numbness on the other hand, disallowed acceptance and a right to honour his own distress. On further questioning Joseph stated that he felt and still feels great loss even to this day. The one person whose needs he had prioritised over his own had taken his sense of purpose. He described that feeling of “underlying sadness” as a “lost sense of purpose”. He was not able to determine if that explained the way he felt as an adult towards himself, seemingly having a

psychological protective barrier to this way of thinking stating “that’s too much for me to get my head around”.

Wanting to change

Joseph started seeing Sally (pseudonym) in June a year later. Sally was 8 years older than Joseph. He described her as solid and strong, and the relationship as good and stable. Sally encouraged and supported Joseph to lose weight. His initial self-directed efforts achieved some success until his weight plateaued at 117 kg (BMI 38.6). Joseph joined a weight loss program the following year. Four months later, Joseph weighed 93 kg (BMI 30.7) but the weight loss company ceased operations. Disillusioned, Joseph stopped trying to lose weight temporarily.

The following year, at 43, Joseph weighed 94.4 kg (BMI 31.2). He commenced an intensive, self-directed weight loss program combining a strict, calorie-controlled diet with intensive exercise. Joseph revised his targets as he reached them. His initial target of 85 kg became 80 kg in July 2008 and 75 kg in August 2008. Achieving targets clearly increased the momentum for further weight loss. In January 2009 Joseph achieved his minimum weight of 63.4 kg (BMI 20.9) and experienced dizzy spells and lack of energy. Joseph saw a sports nutritionist who advised him to eat more carbohydrates. When Joseph demurred, the nutritionist referred him to eating disorders therapy. Although Joseph’s minimum BMI was in the healthy weight range, this period of weight loss most closely resembles anorexia nervosa restricting type in that Joseph maintained a strict discipline and was in close control of his food intake and continually revising down his weight goals. It is likely that he would have kept going if he had not experienced debilitating physical symptoms related to his weight loss. Joseph self-diagnosed anorexia nervosa and began therapy a year later. His therapist also diagnosed depression which she manages jointly with his GP. Joseph reported past episodes of apparent social phobia and

depression (neither of which was formally diagnosed), and no family history of mental illness.

After 12 months in therapy, Joseph has put on 15 kg.

Initially, Joseph continued to believe he was not worthy of help or prioritising his needs. He made the comment “I don’t know why I should feel better.....what right have I got.....I can’t justify feeling better for me”. It was through therapy that he started to change these beliefs and see that he did have a right to be happy. With much effort and support he began to give himself permission to enjoy activities. He was unable to completely separate his needs and others needs however, he found ways to combine others’ and self needs. He started playing a musical instrument and played for pleasure believing that this would bring happiness to both Joseph and his new partner. Although he was able to now connect with his own right to be happy, it was still important for others’ needs to be met.

Joseph moved in with Sally in the following year. He disclosed to Sally his long history of eating disorder and depression and states that she has been very supportive and understanding. Joseph’s eating pattern have improved to some degree usually having two main meals each day. Living with Sally has restricted his ability to engage in disordered food-related behaviour. However, he remains unable to be totally open to Sally. If she is not home, he does not eat disguising this from Sally. He often pretends to eat when she is there. In therapy, he is more open. Joseph explained that he eats little in public and restricts his food intake through small portion sizes, skipping meals, and avoiding foods high in fat, carbohydrates or calories. Joseph uses a variety of compensatory behaviours. He goes to the gym 4-5 times a week for 1-2 hours cardio workout to control weight and still uses diet pills. Joseph had not vomited for weight loss before last year. He vomited for two weeks last year and throughout March this year. The vomiting began when one day he swallowed instead of spat and decided to see “what all the fuss

was about”. He still occasionally vomits. He has vomited twice in the last month but says that he prefers not to as he finds it distasteful and difficult to conceal.

Joseph reported that the work he is doing with his therapist has saved his life and sanity. He still hates his weight and shape, which greatly influence how he feels about himself. He hates looking in mirrors and at photos, and weighs himself every morning. While he remains unhappy with the numbers, he knows he has more energy and is thinking more clearly, and notices deterioration in energy and cognition when he does not eat well. Joseph is trying to eat regularly, think less about food, and avoid vomiting. Having identified as a person with an eating disorder, Joseph has investigated both pro-anorexia and pro-recovery websites. The pro-anorexia sites have increased his repertoire of disordered behaviour.

He is disappointed with the role alcohol has played in his weight increase. He explained that when consuming one glass of wine a week consuming his weight went below 65 kg. Joseph currently drinks up to $\frac{3}{4}$ bottle of red wine (5-6 standard drinks) per night. He finds it easier to eat when he has been drinking as it lowers inhibitions and either generates, or allows him to feel, hunger. Joseph stated that he finds the correlation disturbing because he does not want to be reliant on alcohol to relax or to enable him to eat. “If I do want to eat I want to be able to do it myself.” He fears he has gained weight only because of his drinking. Part of his feeling uncomfortable with his current weight is that, in part, it represents loss of control.

Joseph returned a valid result on the EDI-3. His scores on all scales with the exception of Body Dissatisfaction and Maturity Fears were in the *Elevated* Clinical Range, meaning that they were between the 67th and 99th percentile for the US Adult Combined Clinical sample (comprised of adult females with eating disorder diagnoses). Body Dissatisfaction was at the 66th percentile and Maturity Fears at the 51st. These results indicate a high degree of both eating disorder symptoms and general psychological maladjustment. Joseph scored at the 67th percentile on the

Drive for Thinness scale and at the 87th percentile on the Bulimia scale. His highest score was on the Interpersonal Insecurity Scale which assesses discomfort, apprehension, and reticence in social situations which was at the 99th percentile. He scored at the 97th percentile on Interoceptive Deficits which measures confusion related to accurately recognising and responding to emotional states. High scores on this scale have been associated with poor progress in follow up and predictive of self-injury in patients with bulimia nervosa. His score on the Asceticism Scale is at the 96th percentile (Garner, 2004). These scores are consistent with Joseph's reported history. Based on interviews and the results of the EDI-1 Joseph met the criteria for and Eating Disorders Not Otherwise Specified as per the Diagnostic and Statistical Manual of Mental Disorders criteria (APA, 2000).

Joseph is now able to speak more consciously about feeling depressed and the strong connection he experiences with physical hurt and negative feelings. He recognises his strong desire to self-harm is linked to feeling pain which allows him to "legitimise" his psychological suffering. Getting help meant sitting with the intense feelings of unhappiness and wanting to self-harm yet not act. Therapy slowly untwined this strong connectedness and allowed feelings to be experienced separately to physical suffering. It took Joseph several years of therapy to reduce the intense feelings of the need for pain and suffering and recognise and enjoy feeling happy and well.

Unconditional self-regard was a difficult concept for Joseph. He reported that his biggest struggle in therapy had been doing things for himself. "I feel uncomfortable with this concept". He stills struggles to view others' needs as more "legitimate" than his own. Similarly, he finds it difficult to set goals in seeking help that do not include benefit for his partner. On further interviewing sometime after his initial interviews Joseph was able to realise that his hardest struggle is:

being able to do things solely for me ... I need to learn how to be happy for me, not for other ... I know this now ... but that is hard, a real hard battle which will take me some time.

Joseph reported that he is still undergoing therapy and that he acknowledges that he:

still (has) a lot of work to do ... I have to change my thinking about myself or I'll never be happy ... I have and always will struggle with doing things for me..... but it is getting easier with help from those I know care about me (referring to his therapist and partner).

Discussion

This life history thematic analysis has shed light on a relatively unknown eating condition occurring in males. In particular it highlights that late onset eating disorders are possible in males and that thorough attention to gathering an early life history in relation to current distress levels in this cohort may be therapeutically beneficial. Apart from a *tipping point* that may have precipitated an eating disorder after 40 years of age, this study suggests that positive support may assist a growthful redefinition of self around worthiness and eating, including seeing oneself as legitimate and worthy of happiness.

A tipping point

For many years, Joseph had several risk factors for eating disorders identified in previous research: parental divorce; parental emotional abuse and control; gender role confusion; family overprotectiveness/enmeshment; overweight, body dissatisfaction, and negative affect. However, this case contributes to the literature in that the participant did not develop an eating disorder until at least his late 30s when he probably met criteria for BED in the context of an unhappy relationship. Onset of binge eating in response to negative affect is supported in the literature (Stice, 2002) and often occurs well into adulthood (Striegel-Moore & Bulik, 2007). Joseph did

not attract clinical attention until, at age 44, he sought treatment for an eating disorder closely resembling restricting anorexia nervosa in the context of pre-morbid obesity, dieting, and health concerns, an important contributor and trigger for older-onset patients.

Although psychological distress can negatively impact on dieting and binge eating (Strilo, 2002) a more at risk group may be those who rely on moderate or intermittent dieting to relieve distress (Grilo, Masheb & Wilson, 2001). As such, an individual may have many risk factors for eating disorders without exhibiting obvious or regular behaviours. In this case study the onset of an eating disorder became apparent only in later life despite early life distress and highlights the externalisation of distress may well be disguised through a complex interaction of risk and protective factors. The authors suggest that a *tipping point* for the externalisation of distress in the form of an eating disorder may be reached when an existing risk factor becomes of sufficient intensity, possibly in the context of other stressors (e.g. negative affect in combination with obesity), or new factors emerges (e.g. support from a significant other to lose weight, dieting success, health concerns). The death of Joseph's mother may have heralded such a *tipping point*.

It is likely that the illness and death of Joseph's older brother when Joseph was 8 months old caused significant stress in his family leading to unavailability of his primary caretaker/s, and consequent early attachment development difficulties (Bowlby, 1973). Joseph's history provides ample evidence of a disturbance of attachment: his difficult relationship with his father; his idealisation and emulation of his mother; and his relational difficulties with females during adolescence and adulthood. His restrictive eating at times of relational difficulty suggests a complex link between attachment and eating disorders. Without robust positive self-regard, feelings of unworthiness maintained his self-harm behaviours and inhibited change that would increase feelings of self-worth. However, despite his early life distress, this study highlights that positive support from significant others and/or therapists may have contributed to positive change

and a redefining of self-care particularly when a *tipping point* event in life triggers self exploration. Of therapeutic importance is that despite years of poor interrelational interactions cumulative on early life trauma and abuse, positive psychological support has contributed to positive change for Joseph.

Future research

Future research is needed concerning the role of attachment, trauma and abuse in eating disorders where onset occurs in later life. This study supports a number of established risk factors and has also raised a number of issues which have previously received little attention. Of note are self-induced illness in anxious avoidance particularly in light of early life trauma, abuse and disrupted attachment; significant relationship changes; and opportunity to engage in disordered behaviour. Further case studies exploring delayed onset in males could assist in isolating critical risk factors specific to gender

Strengths and limitations of the study

The methodological approach of this study has allowed the researchers to access a broad range of information and potentially explore issues not canvassed in previous research.

Examining a single case in detail encouraged the participant to explore deeper meaning making at times however, depth of meaning was sometimes limited due to the participant's reticence to explore more deeply.

The major limitation of this study is the dependence on memory (which can often be unreliable) of only one person over a lifetime. However, by allowing Joseph to provide input in various ways: interview; written statements; spread-sheets contemporaneous with his weight loss; and the EDI-3), the researchers have been able to cross reference memory to a greater or lesser degree.

Though qualitative case studies do not offer generalizability or cause and effect, they can generate hypotheses for further investigation. As such they offer the opportunity to explore previously poorly researched phenomena and complement the extant quantitative literature.

Suggestions for clinical practice

This study has highlighted several points of significance for clinical practice. Clinicians treating clients for obesity need to be aware of the potential for eating disorders to develop at any stage of the life cycle. For example, in weight loss programs which monitor progress particularly in a group setting, patients could make extraordinary efforts to perform well to gain praise, or avoid disapproval, or to satisfy their own perfectionistic standards (e.g. starving themselves for a day or two because of an obsessive need to be lighter). Weight loss programs should be required to insure that participants' mental health, particularly any eating pathology, is thoroughly assessed before they commence on any program accompanied by regular monitoring of mental health throughout the program.

Clinicians treating clients with eating disorders need to be aware of the importance of both positive and negative interrelational influences that impact on eating habits and particularly those that may trigger past traumatic events and avoidance behaviours. This is particularly important when there is a trauma history, especially betrayal trauma. A full trauma history may allow traumatic memories verbal expression, so that they can be retrieved from autobiographical memory as required. Without the opportunity to narrate, traumatic memories may be stimulated by unexpected events maintaining behaviours that although protective at another time in life, may reinforce feelings of blame, shame and ongoing psychopathology.

Finally, therapists need to be alert to the possibility that late onset eating disorders may be more prevalent in males than previously recognised particularly if there is a history of early life

Running head: EATING DISORDER ONSET IN MIDDLE AGED MALE

loss and trauma, the client is overweight, and/or has chronically presented with associated and persistent psychopathology throughout life.

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Table 1. Ten distinct phases of participant's life history

| | |
|----------|--|
| Phase 1 | Pre-emigration (1965-1970) |
| Phase 2 | From arrival in Australia until his father leaves for the first time (1970-1974) |
| Phase 3 | From father's leaving to High School and father's first return (1974-1978) |
| Phase 4 | High school (1978-1983) |
| Phase 5 | Post-school (1984-1989) |
| Phase 6 | From move to Canberra to end of marriage (1990-1998) |
| Phase 7 | Hibernation (1999) |
| Phase 8 | Relationship (2000-2005) |
| Phase 9 | Hibernation (late 2005-June 2006) |
| Phase 10 | Relationship (June 2006- present) |

Appendix 1. Semi structured life circumstances interview outline

We will begin by getting an idea of who you are now, how you fit into the world and your relationship with your body.

At this stage I would also like to get an outline of your history.

Later we will go back over your history to better understand your lived experience at different times of your life and how that was affected by events in your life at those times.

Looking back over your life, can you identify any distinct phases, that is, times when your life had a certain consistency which was different from that following some change or transition. For example, most people would consider that their life changed in a major way when they started or left school, or lost a parent, starting or losing a job, or a relationship could also be a boundary between phases of life.

Overall, how do you feel about your life as it is now?

Appendix 2. Supplementary structured interview in relation to current relationship with body and eating and weight related behaviour

We will now turn to your current relationship with your body and a brief history of your eating and weight related behaviour.

Weight history

How much do you weigh now?

How tall are you?

How much would you like to weigh?

What was your highest weight since age 18?

How old were you?

What was your lowest weight since age 18?

How old were you?

What was your highest weight between ages 12 and 18?

How tall were you?

How old were you?

What was your lowest weight between ages 12 and 18?

How tall were you?

How old were you?

How do you feel about your current weight and shape?

How much do you fear gaining weight?

How important is your weight and shape in affecting how you feel as a person?

How do you feel about different parts of your body?

On average, how often do you weigh yourself?

Dieting Behaviour

On average, how many main meals do you have each day?

On average, how many snacks do you have each day?

Are there any foods you try to avoid in order to influence your shape or weight?

If so, what foods?

Have you ever been on a diet, restricted food intake and/or restricted the amounts or types of food eaten to control your weight?

(If NO go to Binge Eating Behaviour)

At what age did you first begin to diet, restrict your food intake and/or reduce the amount or types of food eaten to control your weight?

At what age did you first begin to diet, restrict your food intake and/or reduce the amount or types of food eaten to lose weight?

Over the last year, how often have you begun a diet that lasted more than 3 days?

Over the last year, how often have you begun a diet that lasted 3 days or less?

What are your preferred ways of dieting?

Have you ever used a supervised diet program?

What programs have you used?

How old were you?

Weight at beginning?

Weight at end?

Have you ever used medication for obesity?

What medications have you used?

How old were you?

Weight at beginning?

Weight at end?

Have you ever used psychotherapy for eating problems, weight loss or weight gain?

How old were you?

What forms of psychotherapy?

Weight at beginning?

Weight at end?

Have you ever used psychotherapy for eating disorder?

What forms of psychotherapy?

How old were you?

Weight at beginning?

Weight at end?

Have you ever used medication for eating problems/weight problems?

What medications and what doses?

How old were you?

Have you ever used a self-help group?

How old were you?

Have you ever had a surgical procedure to change your weight or body shape?

How old were you?

Weight at beginning?

Weight at end?

For each diet with major weight loss

How old were you?

Weight at start?

Weight at end?

Type of diet?

Have you ever had significant physical or emotional symptoms while attempting to lose weight or after losing weight?

If Yes, describe your symptoms, how long they lasted, if they made you stop your weight loss program, and if they made you seek professional help.

Binge Eating Behaviour

Have you ever had an episode of binge eating characterized by

(a) eating, in a discrete period of time (e.g., within any two hour period), an amount of food that is definitely larger than most people eat in a similar period of time?

(b) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating)?

(If No go to Weight Control Behaviours)

Please indicate how characteristic the following symptoms were of your binge eating. Options: Never, Rarely, Sometimes, Often, Always

(a) feeling that I can't stop eating or control what or how much I eat

(b) eating much more rapidly than usual

(c) eating until I feel uncomfortably full

(d) eating large amounts of food when not feeling physically hungry

(e) eating alone because I am embarrassed by how much I am eating

(f) feeling disgusted with myself, depressed, or very guilty after overeating

(g) feeling very distressed about binge eating

How old were you when you began binge eating?

When did binge eating start to occur regularly, on average at least 2 times each week?

What was your height and weight at this time?

What is the total duration of time you had a problem with binge eating?

Weight control behaviours

Vomiting

Have you ever self-induced vomiting after eating in order to get rid of food eaten?

(If No go to Laxatives)

How old were you when you induced vomiting for the first time?

How old were you when you first induced vomiting on a regular basis (on average at least two times each week)?

How long did you self-induce vomiting?

Laxatives

Have you ever used laxatives to control your weight or "get rid of food?"

(If No go to Diuretics)

How old were you when you first took laxatives for weight control?

How old were you when you first took laxatives for weight control (on a regular basis on average at least two times each week)?

How long did you use laxatives for weight control?

What type and amounts of laxatives have you used? (Indicate all types that apply and the maximum number used per day.)

Diuretics

Have you ever used diuretics (water pills) to control your weight?

(If No go to Diet Pills)

How old were you when you first took diuretics for weight control?

How old were you when you first took diuretics for weight control (on a regular basis, on average at least two times each week)?

How long did you use diuretics for weight control?

What type and amount of diuretics have you used? (Indicate all that apply and the maximum number used per day.)

Diet Pills

Have you ever used diet pills to control your weight?

(If No go to During the LAST MONTH)

How old were you when you first took diet pills for weight control?

What amounts and types of diet pills have you used in the last month?

During the entire LAST MONTH, what is the average frequency that you have engaged in the following behaviors?

Binge eating

Vomiting

Laxative use to control weight

Use of diet pills

Use of diuretics

Use of enemas

- Use of Ipecac ® syrup
- Exercise to control weight
- Fasting (skipping meals for entire day)
- Skipping meals
- Eating very small meals
- Eating meals low in calories and/or fat grams
- Chewing and spitting out food
- Rumination (vomit food into mouth, chew, and re-swallow)
- Saunas to control weight
- Herbal products ("fat burners")

During **any one month period**, what is the HIGHEST frequency that you have engaged in the following behaviors?

- Binge eating
- Vomiting
- Laxative use to control weight
- Use of diet pills
- Use of diuretics
- Use of enemas
- Use of Ipecac ® syrup
- Exercise to control weight
- Fasting (skipping meals for entire day)
- Skipping meals
- Eating very small meals
- Eating meals low in calories and/or fat grams
- Chewing and spitting out food
- Rumination (vomit food into mouth, chew, and re-swallow)
- Saunas to control weight
- Herbal products ("fat burners")
- Exercise
- How frequently do you exercise?
- If you exercise, how long do you usually exercise each time?
- If you exercise, please indicate the types of exercise you do (fill in all that apply).

Appendix 3: Follow up questions

A semi-structured follow-up interview included questions that explored the intensity of emotion behind some of his behaviours identified in the earlier interviews. These questions probed how the participant felt and what his thoughts were in relation to each theme and comments made.

For example:

- a) You mention that you remember your father being angry, controlling and emotionally abusive. Can you talk further about how this made you feel and how those feelings impacted on your sense of self?
- b) Being invisible or wanting to remain invisible is something you talked about often in the earlier interview. How do you make meaning of this thought and how has it impacted emotionally in your relationships and sense of self in adult life?
- c) In your earlier interview you talked of a sense of unworthiness and not being able to attend to your own needs. Could you further explore this sense that your own needs are invalid or less important than others?
- d) Previously you spoke of a strong desire to self-harm - a physical pain, which allowed you to legitimize your psychological suffering. Could you explore this need to punish yourself further?
- e) One of your main goals in therapy has been to begin to regard and prioritise your own needs which were previously very difficult for you to do. Could you talk about any changes in these thoughts and beliefs and what has impacted that change?